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POLICY

U.S. Navy Medicine is basically an official Medical Department publication inviting the attention of officers of the Medical Department of the Regular Navy and Naval Reserve to timely up-to-date items of official and professional interest relative to medicine, dentistry and allied sciences. The items used are neither intended to be, nor are they, susceptible to use by any officer as a substitute for any item or article, in its original form. The opinions and conclusions expressed in the articles or items included herein are those of the respective authors and do not necessarily represent the views of the Department of the Navy, the Bureau of Medicine and Surgery or any other governmental department or agency thereof.

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The issuance of this publication approved in accordance with NAVEXOS P-35.

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CONTENTS

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This month's cover commemorates the 59th Anniversary of the Navy Dental Corps. Pictured is LT Wayne R. Hawks, DC, USNR, from Springfield, Illinois. Doctor Hawks, who graduated from the School of Dentistry, Washington University, St. Louis, Missouri, is presently assigned to the Naval Dental Clinic, Washington, D.C. The photographer was HM2 Denzel Garner, USN. Another photo appears on Page 6.

Back cover photo by JO3 Robert Joffee reveals CAPT William T. Lineberry, Jr., MC, USN, (left), examining an elderly Vietnamese resident of Tan Phu, RVN, as a concerned grandson watches. The picture provides an interesting character study of three intent faces, reflecting three generations, and the interaction of East-West cultures which time and circumstance have influenced. CAPT Lineberry departed Vietnam in May 1971 and is now Commanding Officer, Naval Hospital Bremerton, Wash.

Page 2 photograph reveals VADM George M. Davis, MC, USN, Surgeon General, addressing the distinguished gathering at the Commissioning Ceremony, U.S. Naval Hospital Roosevelt Roads, P.R., in early 1971. (By courtesy of CDR H. M. Boone, Jr., MSC, USN; Administrative Officer.)

We wish to acknowledge the continued assistance of the Graphic Arts Section, Code 4542, BUMED.

from the Chief

We physicians must maintain high standards in the selection and prescription of drugs. The regulations set forth by the Food and Drug Administration are helpful to us in this regard. Each product which we prescribe must have an official package circular which describes indications, effects, dosages, routes, methods, frequency and duration of administration, and any relevant warnings, hazards, contraindications, side effects and precautions. We all readily agree that these standards are both necessary and valuable in the protection of our patients.

Any mention of the use of marijuana immediately evokes an intense response from the majority of people. In my talks with physicians about marijuana I find, to my surprise, in general they respond with strong opinions pro or con. But, as I research the literature and review what is known about marijuana, I find that the state of current knowledge is meager at best. In few experimental studies has marijuana been administered to humans for extended periods. There are many problems associated with the study of marijuana use which I do not need to reiterate here. It is also not my intent to debate the adverse effects which have been reported to date. However, I must conclude that we do not know enough about marijuana as a drug to endorse its use. There is deplorable ignorance concerning its hazards, contraindications, side effects, and precautions. Until we are more adequately informed, I would suggest that physicians should be very cautious lest they appear to condone the use of marijuana. I fully realize that experimentation with marijuana is widespread. Studies have shown that a high proportion of medical students have used the substance. This in itself makes it difficult for physicians to recommend caution to their patients and associates. However, we must advise caution in the use of marijuana precisely as we should with other drugs about which we have insufficient data.

Laymen look to us for guidance in regard to the use of drugs. The growing widespread use of drugs without supervision and proper reason is alarming to us all. An opinion expressed by a physician is accepted as one which is scientifically based, from an authority on the subject. Therefore, I request that all Naval Medical Officers be extremely cautious in this regard and avoid expressing any opinion which can be construed to justify the use of marijuana.

THE SURGEON GENERAL OF THE NAVY
WASHINGTON

TO THE OFFICERS OF THE DENTAL CORPS

The history of the Dental Corps has been one of continuing excellence and progress. Since 1912 your efforts, and those of your predecessors have made each of you an important and integral member of the Navy's health care team.

Your many contributions to the improved dental health of this nation's sailors and marines — particularly the development of an active and effective preventive dentistry program which includes their families — have added to the already excellent reputation for professionalism that the Dental Corps enjoys. The future holds new challenges and new opportunities and I look forward to your continued support of our efforts to provide the very best medical care to the men and women of the Navy and Marine Corps.

On the occasion of your 59th anniversary please accept my thanks for your outstanding performance and my very best wishes for a Happy Birthday.

G. M. DAVIS
Vice Admiral, MC, USN

DEPARTMENT OF THE NAVY
ASSISTANT CHIEF OF THE BUREAU OF MEDICINE AND SURGERY (DENTISTRY)
AND
CHIEF OF THE DENTAL DIVISION
WASHINGTON, D. C. 20390

FIFTY-NINTH ANNIVERSARY OF
THE NAVAL DENTAL CORPS

22 August 1971

As the Chief of the Naval Dental Corps, it is a pleasure to extend my congratulations and gratitude for your loyal support and cooperation.

Considerable progress has been made in expanded education opportunities, modernization of our facilities and implementation of innovative preventive dentistry programs. The goal is to develop a dental health care delivery system which would encompass professional fulfillment and satisfaction to both the recipient and the provider. Much has been accomplished; much more remains to be achieved. New attitudes and concepts, particularly in prevention, are changing priorities of dental care delivery. We in the Naval Dental Corps, by our personal deep involvement, have the unique opportunity to provide a meaningful service to the personnel of the Navy and Marine Corps, as well as to the dental profession.

On this 59th Anniversary, may our individual and collective efforts further contribute to the growth and development of the Naval Dental Corps as it moves forward to meet the requirements of those it serves.

Happy Birthday!

E. C. RAFFETTO
Rear Admiral, DC, USN
Assistant Chief for Dentistry
and Chief, Dental Division

U. S. NAVAL DENTAL CORPS

On its Fifty-ninth Birthday, August 22, 1971, the U.S. Naval Dental Corps has 1,800 officers and 3,600 enlisted men and women on active duty in 362 facilities ashore and afloat. There are 3,066 dental officers and 2,431 dental technicians on inactive duty in the Naval Reserve. The strength and stature of the Naval Dental Corps is considerably different from what it was 59 years ago when the Commander of the Asiatic Squadron wrote, "The need of a dental surgeon at Olongapo, and in the squadron, is urgent." President Taft signed the establishing Act on August 22, 1912.

During World War I, the small Corps of 30 dental officers expanded rapidly to 500 and the Surgeon General stated that "few remedial measures of recent years have given more satisfaction to enlisted men than the establishment of this Corps."

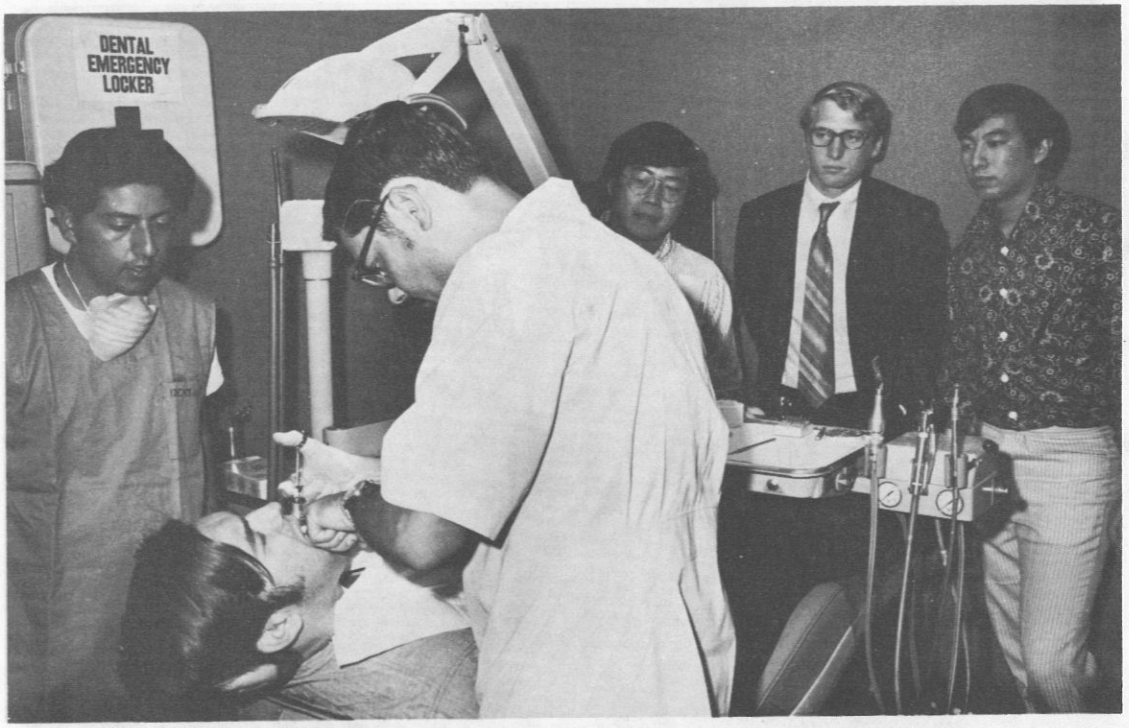
Between World Wars I and II, the Naval Dental Corps made rapid strides in several areas. Recognizing the need for training of both officers and enlisted personnel, the Naval Dental School was established in 1923. In 1935, the 74th Congress increased the dental officer ratio to "one for each five hundred of the actual number of officers and enlisted men of the Navy and Marine Corps." In World War II, the strength of the Dental Corps was about 7,000 officers.

The accomplishments of the Naval Dental Corps are well-known and the Corps has earned a reputation for excellence second to none. Navy dental officers have distinguished themselves by being in the forefront of advances in all phases of dentistry. In the development and use of materials, equipment and techniques, the Naval Dental Corps has excelled. The promotion of water fluoridation and the professionally applied topical application of fluoride are world-known programs. In the field of research and advanced training of dental officers, the Naval Dental Corps stands alone in the extent of its accomplishment.

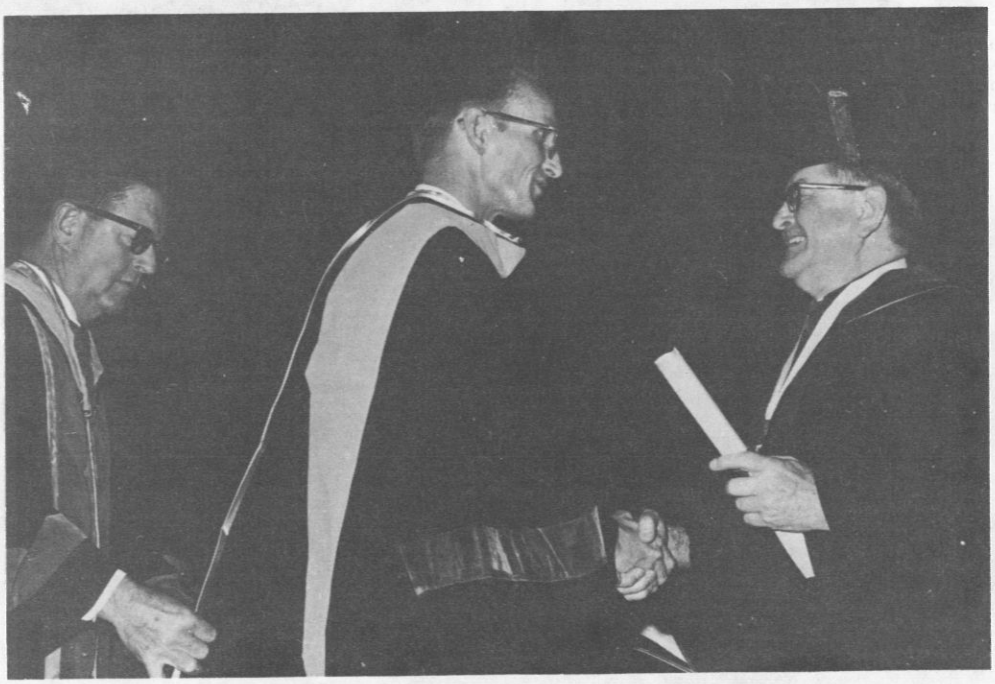
The Naval Dental Corps recognizes its inability to cope with the progression of dental disease, and is focusing its attention on the disease process, rather than treating only the results of disease. Since the principal cause of both periodontal disease and dental caries is bacterial plaque, the Navy Plaque Control Program has been implemented. This program is an integral part of all treatment of Navy and Marine Corps personnel. Prevention is the key to improved dental health and the Naval Dental Ccrps is responding to the challenge.

Dr. Carl A. Laughlin, (left), President Elect of the American Dental Association; RADM Edward C. Raffetto, DC, USN, (center), Assistant Chief of the Bureau of Medicine and Surgery (Dentistry) and Chief, Dental Division, and; Dr. Irving M. Rothstein, General Chairman of the Spring Postgraduate Meeting of the District of Columbia Dental Society Meeting, attended the 20th Anniversary reception of Naval Reserve Dental Company 5-8 of Georgetown University.

LT D.J. Wildes, MSC, USN, Naval Dental School Material Liaison Officer, received the Navy Achievement Medal for his service with the Third Dental Company, Third Marine Division, FMF, Pacific. Presented by CAPT W.C. Wohlfarth, Jr., DC, USN, Commanding Officer, Naval Dental School, the citation read in part: "As Administrative Officer, he displayed outstanding initiative and perseverance, and by his consistently high level of efficiency, materially enhanced the operational effectiveness of his command and gained the respect and admiration of all who associated with him."



Newly refurbished and modernized dental spaces aboard U.S.S. Enterprise (CVAN 65), Senior Dental Officer CDR Ronald M. Gomer, DC, USN, were recently visited by 20 sophomore dental students from the School of Dentistry, University of the Pacific, San Francisco, Calif. Standing from left to right are: DN Charlie V. Martinez; LCDR Milton R. Felger, DC, USN; Mr. Dan Tanita; Mr. Douglas Fastabend, and; Mr. Russell Nakano.



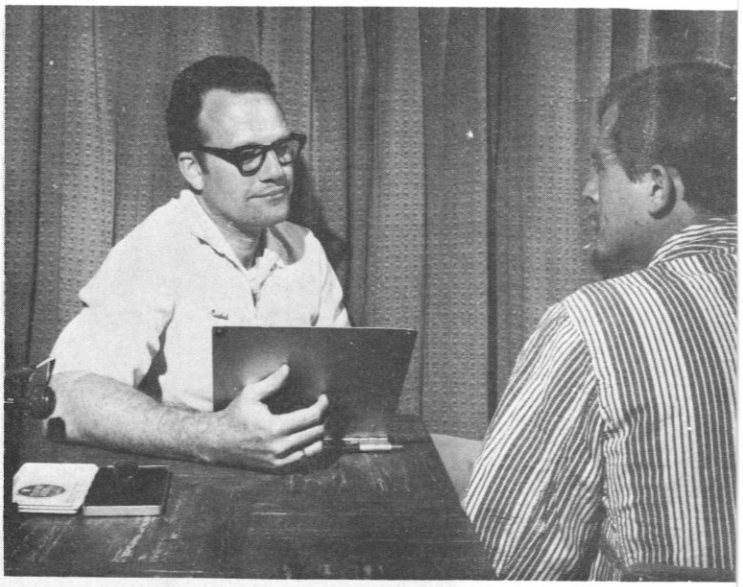
Dr. Charles B. Murto, (left), Dean of Georgetown University School of Dentistry, assists as Rev. Robert J. Henle, S. J., (right), President of Georgetown University, confers an honorary degree of Doctor of Science on Gordon H. Rovelstad, (center), D.D.S., M.S.D., Ph.D., and President of the International Association of Dental Research. CAPT Rovelstad, DC, USN heads the Research Branch of the Dental Division and is Program Manager for Dental Research of the Research Division, BUMED. The degree of Doctor of Science was conferred, citing his achievements "to increase scientific knowledge of the complex problems of caries, the major dental disease, with particular emphasis on the child patient." CAPT Rovelstad delivered the address at the School of Dentistry commencement exercises.

On 16–18 Nov. 1970, the Naval Dental School, NNMC, Bethesda, was host for the first Navy Conference on Prosthodontics Training. Under the chairmanship of CAPT S.O. Bartlett, DC, USN (front row, fourth from the left), Head, Prosthodontics Department, the group convened to study ways of finding practical solutions for problems associated with prosthodontics training.

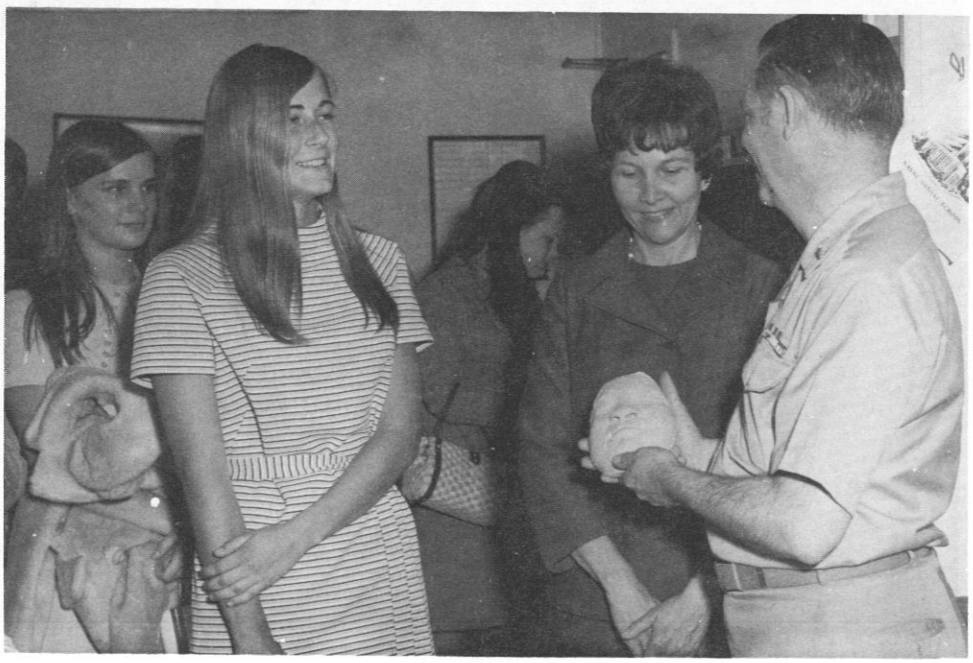
At the Spring Meeting of the Academy of Stomatology of Philadelphia, Pa., Dr. Lester Burket, Dean, University of Pennsylvania School of Dental Medicine; Dr. Muller DeVan, Prosthodontist; Dr. Louis Grossman, Endodontist, and; Dr. James Cameron, Oral Surgeon (Posthumously) were presented plaques in recognition of over 20 years' service as consultants at Naval Hospital, Philadelphia. CAPT H.S. Samuels, DC, USN, then Chief of Dental Service at the Philadelphia Naval Hospital (now at Naval Hospital, Oakland, Calif.), presented attractive plaques to the honorees and moderated a program presented by: CDR J.I. Johnson, DC, USN – "The Navy's Preventive Dentistry Program"; CDR M.S. Burch, DC, USN – "Resumé of Management of Orofacial Injuries"; CDR W.D. Loo, DC, USN – "Management of Challenging Prosthetic Problems in a Hospital Environment."

VADM George M. Davis, MC, USN, Surgeon General, addressed the Naval Reserve Dental Symposium held in Las Vagas, Nev., in Nov. 1970. To his right is pictured the "Most Outstanding Dental Company Award" presented to Naval Reserve Dental Company 3-4 of Long Island, N.Y., and accepted by CDR Edward J. O'Shea, DC, USNR-R, the Company's CO. The handsome trophy will be given annually and was donated by CDR William J.H. Vaughn, DC, USNR-R, CO Naval Reserve Dental Company 8-5 of Dallas, Tex.

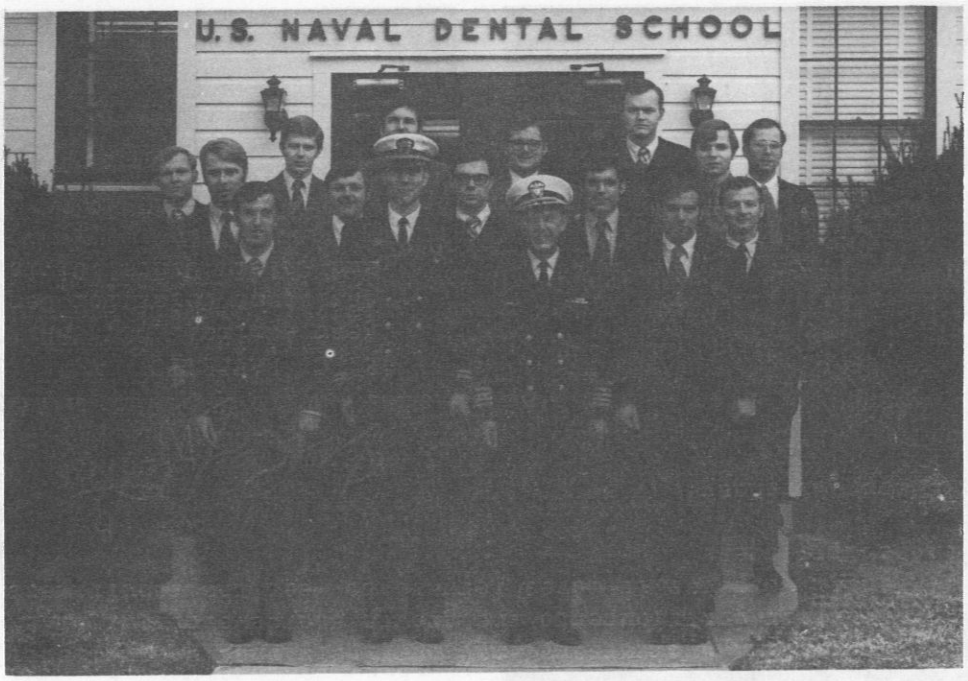
After his lecture on "A New Direction for Dental Education Today and In The Future," Dr. Joseph L. Henry, (right), Dean, College of Dentistry, Howard University, was presented with a Naval Dental Corps plaque for his continuing support of the Naval Dental School, by the Executive Officer CAPT W. A. Monroe, Jr., DC, USN.



LT Richard L. Cannon, DC, USN, Assistant Dental Officer of the attack aircraft carrier U.S.S. Constellation, interviews each surgery patient before administering anesthesia, to determine the medical history and alert the surgeon to any unusual features in the history. Dr. Cannon is one of three qualified anesthetists on board the CONSTELLATION, and he initiated the interest that led to the qualification of his two associates. The dentists received their initial anesthesia training at Naval Hospital Bremerton, Wash., under the staff anesthesiologist LCDR C. W. Bollinger, MC, USN, and LT R. D. Shannon. The professionally talented colleagues of Dr. Cannon aboard CONSTELLATION are: LT Carl M. Schneider, DC, USN and LT Charles L. Boelter, DC, USN.



Demonstrating the diversification offered in a nursing career, CAPT S. O. Bartlett, DC, USN, Head, Prosthodontics Department, Naval Dental School, displayed a face mask for students from the Frank W. Cox High School, Virginia Beach, Va. A group of 30 students visited the Naval Dental School, NNMC, in the course of a medical indoctrination and orientation visit.



Fourteen members of Naval Reserve Dental Company 5-8 toured the clinical and educational departments of the Naval Dental School, NNMC, Bethesda, last Dec. 1970. The Company's commanding officer, CAPT A. G. Paulsen, DC, USNR-R is seen standing in the front row, third from the left.

Dr. Donald Welk, (left), Chairman of the Department of Restorative Dentistry of the University of Oklahoma Dental School, presented a two-day program in Operative Dentistry at the Naval Dental School, which was attended by approximately 100 military and civilian dentists. Appreciation was expressed by CAPT Loren V. Hickey, DC, USN, (right), Head of Operative Dentistry at the Naval Dental School, NNMC, Bethesda.

CAPT Joseph Cormier, RCDC, (second from the left), received a certificate for completing a seven-week prosthodontic course in April 1971 at the Naval Dental School. Pictured with him, standing from left to right, are: CAPT Ronald G. Granger, DC, USN, Head, Fixed Partial Denture Division; CAPT Stephen O. Bartlett, DC, USN, Head, Prosthodontics Department, (now retired) and; CAPT Robert W. Elliott, DC, USN, Head, Complete Denture Division.

Dr. Edward L. McGlone, (left), Dept. of Speech, Wayne State University, Detroit, Mich., was presented a certificate of appreciation for presentations in the first Management Seminar for Senior Dental Officers held at the Naval Dental School in May 1971. Dr. McGlone discussed conference leadership and communications in business organizations. CDR Fred C. Ulmer, MSC, USN, (right), was the director of the course.

(We wish to acknowledge the PAO source of the material used in this review. Much of it was provided by the PAO, NNMC, Bethesda, Md. Does the Public Affairs Office at your activity forward photographs to U.S. NAVY MEDICINE? Why don't you inquire about it? We'd like to include you in our news.)

MYSTERY HOUR

By CAPT William E. Ludwick, DC, USN, Headquarters, Fleet Marine Force, Pacific, FPO San Francisco, Calif.

"Captain, mystery hour is coming up tomorrow." This announcement was made by my dental technician the first day I took over the dental department of the U.S. Naval Support Activity, London, England in 1959. Since I was busy examining a patient, no inquiry was made as to what was meant by the remark, although, my curiosity had been aroused. After the patient had departed, the matter of the mystery hour was taken up with the originator. I felt a bit uneasy having to ask this young naval strategist of less than 18 months' service to explain the jargon of my department's operations.

"Mystery hour" was his terminology for dependent wives' sick call which was scheduled for every Tuesday afternoon between the hours of one and two. I required further explanation. He promptly pointed out that the "mystery" lay in the fact that anywhere from 0 to 50 wives might show up.

During the time that my next patient was being seated, I began to think about tomorrow's sick call and what kind of turnout we might have. However, I busily engaged in the work at hand and thoughts of "mystery hour" soon left me. But not for long, as my technician soon interjected another provocative remark, blurting out the following: "I hope that not too many 'Fish' show up tomorrow." Resultant discussion revealed that "Fish" was his term for dependent wives appearing at sick call.

I was disgusted with myself for having been led into this latest conversation in front of a patient, as it dawned on me that the patient's wife might some day attend sick call; and if so, he knew she had been ignobly classified by my "leader." He further heard how several wives came "dragging in" at the end of sick call the week before and how they "fouled up" the schedule for the entire day. I definitely did not like what the patient was hearing.

The next morning, while conducting sick call for military patients, I was exposed to more of my technician's comments about wives' sick call. My technician was hoping for a light sick call and I must admit that my thoughts were in agreement with his.

By this time it was obvious that the military sponsors could easily gain the impression that their wives were not particularly welcome in the clinic. Also, it was apparent that the sponsors were being herded through sick call in a rather impersonal manner. Each time one was dismissed, my technician called out "next" and another would appear. It was difficult to tell whether he was a member of the Army, Navy, or Air Force as military uniforms were not being worn in London at that time. While I could learn his name from the record, if he had one, I found myself asking if he were "so and so" and frequently being told that he was not, as the records were not always in order. Also I did not know the reason he was attending sick call.

While departing for lunch that morning, I noticed that the waiting room was almost filled with women and children. I asked my "leader" why they were so early. His reply was straightforward and to the point. "They want to be at the head of the line for sick call."

Eating lunch while reflecting that your waiting room is already filled with patients waiting for an event not scheduled to commence for another hour, is not conducive to good digestion or peace of mind. I "wolfed" my sandwich and hurried back to find that the number of patients had increased to the point where there were insufficient chairs to accommodate all of them. Two were standing, one of whom was holding a small baby. I quickly rolled up my sleeves and took to the task at hand, as my technician assured me that "we will set a record today."

With the assistance of another dental officer we examined the patients and advised them when they might return for treatment. As the patients were being examined, I could hear the other dental officer asking his technician, from time to time, how many more were still awaiting examination. I was asking mine the same question and was delighted when I was informed that there was only one left.

I figured that my colleague could see this last patient and took a little longer examining my patient. Apparently he had the same idea as I, for he was also in no particular hurry to call in the last patient. Before either of us managed to outwait the other, another patient arrived, thereby giving us each one last patient. I might add that my "leader" expressed

himself most articulately on this occasion, though his commentary would not likely inspire patient confidence or trust. When sick call was finally completed, not only were we late for regularly scheduled appointments, but in reality nothing had been accomplished for the patients examined.

I well remember the conversation with my last sick call patient that day. She had taken public transportation, which required making two transfers, and was carrying a small baby that was sick with a cold. Upon examination, I told her that she had lost a filling. She responded, "Yes, it fell out last night during dinner." She then went on to say that that was the reason she had come to sick call. My brilliant diagnosis was something she already knew. With some embarrassment, I had to inform her that I could not put in another filling at this time and that it would be necessary for her to return in two weeks to have it replaced. A sedative treatment was hurriedly placed and she was dismissed. By this time, my two o'clock patient had been waiting for almost an hour.

Since "mystery hour" for children was scheduled for Saturday morning, I began to anticipate what it might bring. The way it turned out, the event could best be described as a near stampede. The dental clinic was situated on the second floor. As I stepped into the waiting room I could see that the room was filled and there were parents overflowing into the stairway with little ones in tow. Also, I noticed that one mother, whom I had seen during wives' sick call, was back again with her children.

It was ruefully apparent that I had no control over sick call. This was an unpredictable event and the term "mystery hour" was indeed accurate. Obviously, something had to be done to improve the service. I somehow had to develop a method of providing more care and in a more orderly fashion. But even more important, it was necessary for me to become the leader of the clinic and master of the situation.

I held sick call seven times a week — five for military patients, one for wives, and another for dependent children; each session lasted an hour or more. Approximately one-fifth of my working time each week was devoted to "mystery hour" activities. Instead of considering how I might deliver better health care service for more patients, I found myself secretly hoping that each sick call would be sparsely attended. What a poor way to run a clinic!

After contemplating the clinic operations, in detail, I spent many hours attempting to devise a system which would benefit the patients as well as the staff. The one central thought that remained uppermost in my mind was the elimination of the conventional sick call system, and inviting all patients to call and make appointments before coming to the clinic. When this concept was first presented to my two associate dental officers, many sound and carefully thought out objections were advanced. Later, the proposed plan was put to our five dental technicians, our civilian hygienist and civilian receptionist. Their response was also less than encouraging.

Finally, an appointment system was developed for the 1500 military and approximately 1400 dependent patients. It was agreed that it would be tested for three months and, if found unworkable or unsuccessful for any reason, that it would be discontinued or modified. It was not necessary to make any alterations to the clinic facilities. The five dental operatories, small prosthetic laboratory, and accessory spaces were quite adequate. One of the operatories had an X-ray machine, serving the dual purpose of X-ray room and dental operating room.

End of Mystery Hour

An announcement was published in the Plan-of-the-Day which invited all patients to call for an appointment before coming to the clinic. As the calls came in, the caller usually indicated why he was calling. The most frequent reason voiced was a request for dental examination. The receptionist gave each caller a 20-minute appointment; beside the patient's name and telephone number a simple notation was made which indicated the main reason given for seeking an appointment.

Patients in pain were told to report immediately; however, these cases were few and could be easily handled. Patients who would just walk in, rather than call, received appointments for a subsequent day or were seen immediately should cancellations develop. It was usually possible to schedule the annual physical examinees for a 20-minute appointment by working closely with the Medical Department. This was very helpful for all concerned, permitting a thorough examination and discussion of the patient's dental condition with him.

After the first day with the new program, my technician never mentioned "mystery hour" again. Every night before he left the clinic he could see at a glance the names and the number of patients scheduled for the following day, together with the general nature of each appointment. This information was also beneficial to me. It gave each of us an opportunity to think about the next day and to mentally prepare ourselves for the type of services we would be rendering. For the first time I had complete control over the situation

and could schedule the patients in an orderly fashion, in accordance with the treatment capabilities of the dental staff.

As the patients arrived for their appointments, they were seated in either my operatory or the adjacent auxiliary office. I examined each patient with a small universal scaler and removed any gross calculus. In many cases, particularly with small children and young adults, it was possible to complete the procedure within a few minutes. If no other treatment was required, my technician pumiced their teeth.

While he was pumicing the teeth, I moved to the auxiliary office and started the next patient. If this patient required a small restoration, it was placed and an effort was made to complete the essential treatment regardless of its nature. It was surprising how many patients completed all necessary treatment during their initial appointment.

While three patients were scheduled for each hour, each one could receive almost 40 minutes of treatment time, 20 minutes of my time and 20 minutes of the technician's time. The technician's services consisted of oral prophylaxis, taking of X-rays and assisting with preventive dentistry instructions. He became a very busy individual providing much valuable service.

The patients requiring extensive treatment were managed in a different manner. After the examinations had been completed, some type of treatment was accomplished. Then the patients were introduced to one of my colleagues who completed the treatment in a subsequent appointment, if possible. The personal introductions were greatly appreciated by the patients.

The appointment sick call system enhanced the image of the Dental Department overnight. No longer was it necessary for patients to attend sick call just to make an appointment. This convenience saved patients many hours. It was possible for a family to call and make concurrent appointments for all members. The new system proved to be beneficial to me. I could control the flow of patients and more effectively utilize the treatment capabilities of dental personnel to better meet the dental needs of the command. Furthermore, it gave me more time to stress the importance of preventive measures with each patient. It was possible for me to see 20-22 patients daily, 100 a week and 400 a month. In an eight-month period, there were more than enough appointments available so that each patient authorized to receive treatment could be seen at least once.

Discussion

Since 1960, I have extolled the benefits of an appointment sick call system. I have listened to all the reasons why it will not work at particular commands. Many of these reasons are sound and perhaps at some commands an individualized appointment system is not feasible, particularly at recruit training centers.

One of the main objections to the system is that the patients requesting appointments do not really know what they may require, and therefore they should be examined prior to any treatment. I do not concur with this line of reasoning, as I know that it is possible to examine a patient and provide some definitive treatment during the initial appointment. I do not include diagnosis and X-ray studies as definitive treatments in this system. These procedures can be accomplished along with scaling or some other procedure during the first appointment.

Among other objections raised is the fear that the "phone for an appointment system" would produce a flood of requests that could not be dealt with in an orderly manner. If this were the only objection, it could be controlled by permitting specific categories of personnel to request appointments initially, and gradually including others as the system gains momentum.

Within the past six months two Marine Corps activities have agreed to try the system. LCDR George W. Oatis, Jr., Marine Corps Air Station, Iwakuni, Japan has reported the following information:

"I just thought I would drop you a note to let you know that some of the suggestions you made in October are now in effect and seem to be going well. We did away with sick call and all examinations and treatments are now on an appointment basis. We have two dental officers seeing the patients on a one-half hour basis. I thought every 20 minutes was a little short for a start. With the new system we have we can now see 150 patients on a first-time basis. Also we now have a treatment plan which makes things go much more smoothly."

In February he made an additional report:

"I am very happy with the new appointment system. Within the past five weeks we have cut our weekly sick call from an average of 137 down to an average of 8. With two officers working on one-half hour appointments, 136 patients are seen per week, so we are holding our own. As the result of a little study I did on the amount of time being spent by patients at sick call, I would estimate that with this new system we can save the command 3600 man hours per year. The system is only as good as the officers involved and I am fortunate to have two very good officers working at it. If we get booked too far in advance with our operative appointments, I cut back on

the half-hour appointments until we get caught up. The patients seem to be very happy with it, especially the dependents."

LCDR T. W. Mansfield, Marine Corps Air Station (Helicopter) Futema, Okinawa has submitted the following:

"It has been one month since I have taken over the dental department. As you requested, I'm sending this synopsis of accomplishments during this period of time.

"The system for sick calls as suggested by you has been put into effect. We still have a regular sick call for physical examination. As yet, we have not been tested in the sick call area as we have been able to treat all that have come in. No one leaves the clinic without some form of treatment. The recall system that I had hoped to put into effect will not work here as very few people are here longer than eight months. Station personnel are the only people remaining here for any length of time and they account for but a small percentage of the people. Class III patients are given priority over everyone else."

In his latest communication, LCDR Mansfield has stated that the personnel turnover is so great that the appointment system is not working as smoothly as expected. The short appointment system has been put aside for the time being because of an influx of many patients needing extensive operative treatment (Class III patients). As soon as the number of Class III patients is reduced to a reasonable level, the clinic will again test the appointment sick call system.

The appointment sick call system is finally gaining some support. Had it not been for the vivid and accurate description voiced by my technician, DT3 Dennis J. Orr, it is doubtful that I would have arrived at the realization that the "mystery hour" could be eliminated. After all, I had engaged in "mystery hour" activities for almost 20 years before I met him.

Conclusion

An appointment sick call system better serves the needs of patients. It is more convenient and saves them many hours each year. Furthermore, it gives dental personnel better control over the planning and delivery of dental health care programs for the command.

THE SECRETARY OF THE NAVY

WASHINGTON

TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

Congratulations and sincere best wishes to the officers of the Medical Service Corps upon the occasion of the Twenty-fourth Anniversary of the establishment of the Corps.

The Navy Community depends upon the material contribution of the Medical Service Corps for the maintenance of health. The officers of your Corps have established a splendid record and reputation for high achievement and dedicated service to the Navy. I have every confidence that the talented officers of your Corps will continue to serve wherever they are needed with zeal and deep devotion to duty and to exercise their skills for the common good, for the Corps, for the Navy Medical Department, and for the entire Navy Community.

I wish to take this opportunity to commend you for a job "well done" and to wish you continued success wherever you are serving.

John H. Chafee

JOHN H. CHAFEE

CHIEF OF NAVAL OPERATIONS

TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

It is with pride and pleasure that I greet you on this happy occasion of the Twenty-Fourth Anniversary of the establishment of the Medical Service Corps.

The men and women of your Corps have distinguished themselves professionally, both individually and collectively, and on both local and national levels. You may justifiably take pride in the contributions you have made to better health-care services. The Navy has never had a greater need for talent. The burgeoning health-care needs of the day urgently require every bit of professional expertise and keen health-care management that can be mustered. I have great confidence in your ability to rise to these challenges.

Every good wish for your future success and HAPPY BIRTHDAY!

E. R. ZUMWALT, JR.
Admiral, U.S. Navy

THE SURGEON GENERAL OF THE NAVY
WASHINGTON

TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

Sincere congratulations on this Twenty-Fourth Anniversary of the establishment of the Navy Medical Service Corps.

It is a pleasure to convey to you my personal appreciation for your contribution to the accomplishment of the mission of the Navy Medical Department. The Medical Department has in the past and will in the future continue to rely upon the many talents of the officers of your Corps. The future is abundant with opportunities for those officers who can innovatively meet the challenges of providing increasingly sophisticated health-care services where they are needed. I have every confidence that the officers of the Medical Service Corps will meet these challenges with continuing loyalty and devotion to duty.

Warm personal regards to each and every one of you and best wishes for a HAPPY BIRTHDAY!

G. M. Davis

G. M. DAVIS
VICE ADMIRAL, MC, USN

DEPARTMENT OF THE NAVY
ASSISTANT CHIEF OF THE BUREAU OF MEDICINE AND SURGERY (DENTISTRY)
AND
CHIEF OF THE DENTAL DIVISION
WASHINGTON, D. C. 20390

2 June 1971

TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

On behalf of the officers of the Naval Dental Corps, I wish to extend hearty congratulations to each of you on the occasion of the Twenty-fourth Anniversary of the Naval Medical Service Corps.

Medical Service Corps officers serve with distinction and have established an outstanding record of accomplishment. The notable achievements in support of all phases of the Medical Department operations reflect great credit on your professionalism, loyalty, and dedication to duty.

Contributions made by the Medical Service Corps to the overall management of dental health programs have been most helpful in the accomplishment of the mission of the Naval Dental Corps.

Congratulations and best wishes for your continued success.

E. C. RAFFETTO
Rear Admiral, DC, USN

DEPARTMENT OF THE NAVY
CHIEF OF THE MEDICAL SERVICE CORPS
BUREAU OF MEDICINE AND SURGERY
WASHINGTON, D. C. 20390

ANNIVERSARY GREETINGS

from the

CHIEF OF THE MEDICAL SERVICE CORPS

It is with pride and pleasure that I extend warm personal greetings to each of you upon the occasion of the Twenty-Fourth Anniversary of the establishment of the Navy Medical Service Corps.

As we begin our twenty-fifth year of service we look to the future with confidence in our abilities and enthusiasm for accomplishing any tasks which may be assigned. Our confidence is founded upon a solid record of prior accomplishments for which each of you may take special pride.

The high calibre of the varied talents of the officers of the Medical Service Corps generates within our Corps a contageous attitude of enthusiasm. It is with this spirit of enthusiasm that we shall welcome the challenges of the future.

Best wishes to all for a bright and fruitful year ahead, and HAPPY BIRTHDAY!

E. L. Van Landingham Jr.

E. L. VAN LANDINGHAM, Jr.
Captain, MSC, USN

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20390

TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

On behalf of all Nurse Corps Officers, I extend heartiest greetings and congratulations on the occasion of your Twenty-fourth Anniversary.

Since the establishment of your Corps, each of your officers have met the challenge of your mission in time of peace and war with fidelity and sincerity. Your contributions to Navy Medicine, Research, and Hospital Administration are recognized and respected at all levels of the Department of Defense and civilian medical communities.

The support and cooperation received by Nurse Corps officers from members of the Medical Service Corps throughout the years are deeply appreciated.

We join your many friends and associates in saluting you on this memorable occasion.

Alene B. Duerk

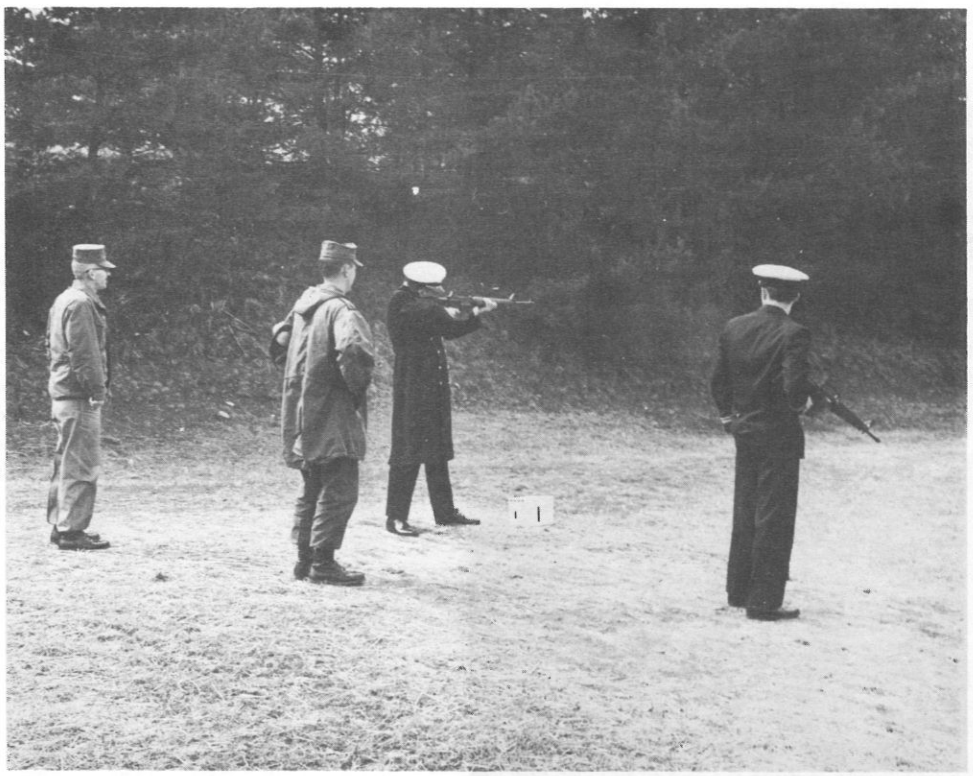
ALENE B. DUERK
Captain, NC, USN
Director, Navy Nurse Corps

A MILESTONE FOR THE MEDICAL SERVICE CORPS

This year marked the first year that women, as well as men, received their orientation at the Naval School of Health Care Administration (NSHCA), National Naval Medical Center, Bethesda, Md. The innovation was established on 1 January 1971. All Medical Service Corps officers, except aerospace physiologists and psychologists, now receive their orientation into the Navy at NSHCA.

According to the Commanding Officer, CAPT R. M. Tennille, MSC, USN, the other two courses at NSHCA will also accept women officers under the new procedure. The courses offered at NSHCA are the Orientation Class for recent college graduates in health care fields who have received direct appointments as Medical Service Corps officers, the Indoctrination Course for in-service selectees, and the course in Health Care Administration.

Military Drill is a part of the Orientation Curriculum for all Medical Service Corps officers, both men and women. Having a podiatrist in the class is a real help for those "soft of foot."



While optometrists, pharmacists, therapists, and scientists are not called upon to fire the M-16 rifle, part of the Orientation Curriculum at the Naval School of Health Care Administration includes a visit to the Marine Corps Base at Quantico, Va., for familiarization firing of weapons.

Members of a Medical Service Corps Orientation class examine a 40 mm. mortar tube during a familiarization visit to the Marine Corps Base, Quantico, Va.

New officers in the Medical Service Corps can find answers to most of their questions in the volumes used in their class work. More meaningful, however, is the personal attention afforded each student by the faculty of NSHCA during hours of individual counseling and study.

Adjustment to the Navy includes learning to properly wear a new chapeau. The first two women officers to attend NSHCA are helped with their fittings by LT Pat Evans, MSC, USN.

The newest members of the Corps share a light moment with their "salty shipmates."

Members of Health Care Administration Class No. 31, 1969 – 1970, stand while receiving the class charge from the Chief of the Corps, CAPT Emmett L. Van Landingham, Jr., MSC, USN, at Graduation Exercises on 12 June 1970.

DUTY WITH INSURV

By LCDR R. R. Kenlon, MSC, USN, Board of Inspection and Survey, Navy Department, Washington, D. C.

INSURV, the acronym for Board of Inspection and Survey, Navy Department, derives its present day organization from an Act of Congress dated 5 August 1882. The need for such a board, its responsibilities herein later defined, was apparent for many years prior to its formal establishment when ship inspections and trials were at best a hit-or-miss proposition. Recognition that inspections are necessary for effective creativity can be traced to the Good Book where it is written that when the Almighty completed His work, He "saw it was good" – probably meaning that He inspected it and found it satisfactory. Ever since, the principle of a final test for a finished product has been accepted.

Purpose and Location

INSURV is a duly constituted Statutory Board composed of naval officers for the purpose of witnessing

LCDR R. R. Kenlon, MSC, USN, (left), consulted with Philadelphia Naval Shipyard Trial Officials prior to INSURV of USS Luce (DLG - 7), 7 - 10 June 1971.

The author, (right), is pictured inspecting sick bay in USS Luce. Observing the inspection are LCDR J. S. Willens, MC, USNR, (left), and HMC Tommy Ruffin, USN, (center).

and submitting detailed reports upon trials and inspections of naval ships.

The main Board is located at the Arlington Annex, Arlington, Va., with Sub Boards located in Norfolk, Va.; San Diego, Calif.; and Patuxent River, Md.

Principle Function

The Board reports to SECNAV, through CNO, the material readiness of the Fleet in a three-fold manner by:

1. Inspecting all newly constructed naval ships and aircraft, determining their ability for sustained reliable service, and insuring that the contractor has constructed each craft in accordance with the terms of his contract;

2. Inspecting all active service ships every three years to determine their material condition for continued active service;

3. Inspecting all ships being considered for deactivation in order to support a decision to decommission, or to strike from the list.

Members

Permanent members are naval officers of known specialties and expertise with the ability to thoroughly and objectively evaluate and report, within their area of competency, on a ship's material condition. Periodically, due to type and class of ship, it is necessary to draw on additional military and civilian experts who act as assistant inspectors.

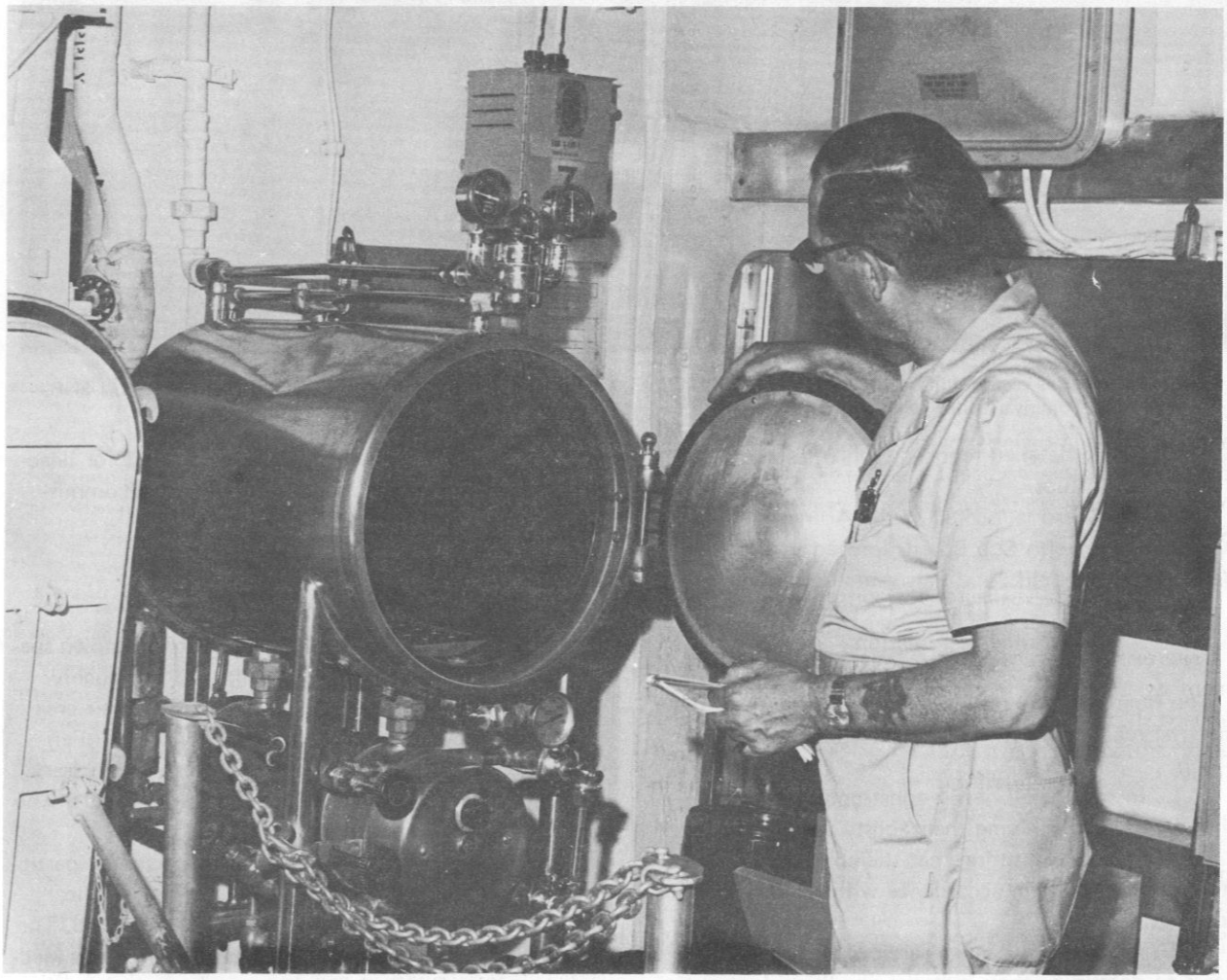
The history of Medical Department personnel participation in INSURV is interesting. In 1882, Medical Director Gihon was assigned duty with the Board. The last recorded permanent member, until 1970, was Medical Inspector Dr. Paul Fitzsimons, who served until January 1898.

During subsequent years, the program for medical inspectors serving with INSURV was an "ify" situation in which nonprofessional members were drawn from all areas, given a check list and told to have at it. Since the establishment of the Medical Service Corps in 1947, MSC officers have been normally assigned the collateral duty of assisting INSURV within their Naval District. For example, the LANT Sub Board drew assisting inspectors from the Norfolk area; PAC Sub Board drew from COM 11; submarine assistants were drawn from various submarine centers; and the Main Board drew assistance from BUMED and the Washington area. Such an arrangement was often burdensome and unsatisfactory for the individual assistant and his command.

Finally, in April 1970, a permanent member was assigned as the Medical Inspector on a full-time basis. Following some 29 years' experience in evaluating Medical Departments both at sea and ashore, it was my privilege to become the first permanent medical member in over 70 years. Previous assignments with two reserve fleets, six active ships, and two and one-half years of INSURV support with COMTHIRTEEN, stood me in good stead. Paving the way toward making the Medical Inspector a valuable adjunct to INSURV, the Medical Department, and the ship construction program as a whole, was an exciting challenge.

Guidance for formulating the inspection procedure was provided by: thousands of discrepancy cards developed from hundreds of acceptance, underway, and final contract trials; material and inactivation inspections; numerous consultations with fellow inspectors, Fleet Support Division, BUMED; NAVSHIPS and type commander representatives; contractors, and; ships force medical personnel.

A detailed, comprehensive inspection procedure was developed and set forth, in accordance with general



LCDR Kenlon inspects autoclave at Forward Battle Dressing Station (FBDS), USS Luce.

As part of the sanitation inspection phase of INSURV, the author inspects the crews galley (vegetable preparation room) in USS Luce.

and detail specifications for construction of naval ships, the Manual of the Medical Department, the Manual of Naval Preventive Medicine, and the Navy Directives System.

Medical Inspector Responsibilities

The responsibilities of the Navy's Medical Department transcend all divisional and departmental lines aboard ship. All facets of shipboard life are considered. Primarily concerned with "eyeball to hardware" throughout the ship, during the course of a trial the inspector must basically ascertain:

a. Has the designer provided and equipped the medical complex to give the doctor and corpsman a facility in which to practice modern medicine?

b. Has the contractor constructed and equipped the spaces according to ship's specifications?

The five-day inspection includes the following considerations: (1) a thorough and detailed look at medical spaces, (2) the casualty handling capability, (3) the environmental aspects in conjunction with habitability, (4) the public health aspects, and (5) documentation of discrepancies and letter reporting.

A typical inspection onboard a newly constructed destroyer type would frequently require two days underway in an operating area and two days in port. Normally, during the at-sea phase, the areas of environmental habitability, safety, and health aspects would be observed as the ship is put through her paces while fully operational. Temperature measurements in the fire room, surgical room and living compartments are recorded. Ventilation and noise levels are evaluated in crew working spaces, and, a complete sanitation inspection of all food service areas such as crews galley and its adjacent spaces is conducted. CPO and wardroom messes, and CO/Flag Pantries are checked, particularly noting violation of sanitizing capabilities, food

preparation, and stowage techniques. Handling of potable water, both the shipboard method and shore-to-ship transfer method, is most carefully scrutinized with particular attention being paid to testing techniques for determining water purity, the operation of installed automatic hypochlorinators, stowage of fresh-water handling equipment, and the interior condition of the fresh-water storage tanks.

An evaluation of the adequacy of installed equipment and quality of construction in accordance with contract specifications, is made. The casualty handling capability receives close attention in the areas of battle dressing stations, first-aid boxes, stretchers, routes to and from decontamination stations, storerooms, medical chests, and outlying equipment. Safety aspects in machine shops, electronic spaces, and weaponry areas are noted.

No effort is made to evaluate either personnel or administration aboard ship. No effort is made to redesign the ship or pass judgment on the designer or builders. The basic philosophy of INSURV is to objectively inspect and report violations of construction and operational capability of the equipment. This mission is accomplished, week after week, ship after ship.

Probably the most rewarding aspect of the job is the opportunity to instruct "first time at sea" medical personnel and informally advise commanding officers concerning the many opportunities for improving health care delivery techniques. Such information is made available through firsthand knowledge of the Navy Directives System and manuals. The physical locations of many shore base activities that offer training to forces afloat can be readily provided. Enthusiasm can then be generated which will lead to better medical support of our men at sea.

HONORS TO NAMRU-2 STAFF

At the 19th Annual Meeting of the American Society of Tropical Medicine & Hygiene held in San Francisco, Calif., 1-4 Nov. 1970, the award for best slides was presented to the following members of NAMRU-2 staff: CAPT R. H. Watten, MC, USN, Commanding Officer; CDR G. T. Strickland, Jr., MC, USN; LT M.J. Tong, MC, USNR; and Dr. C.V. Uylangco, U.S. Naval Medical Research Unit No. 2, APO San Francisco 96263, and San Lazaro Hospital, Manila, Philippines. The First Place Award was bestowed in recognition of the outstanding quality of slides used to illustrate the scientific paper entitled, "An Evaluation of Oral Therapy for Asiatic Cholera."

(Continued from p. 37)

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NAVAL PHARMACIST — ITALIAN STYLE

By CDR Robert L. Smith, MSC, USN; Chief, Pharmacy Service, Naval Hospital Boston, Chelsea, Massachusetts 02150.*

"BENVENUTO A NAPOLI": A familiar greeting to all military families destined for duty in Naples, Italy. Such a friendly welcome conjures up dreams of giant pizza pies, lasagna, ravioli and other gastronomical delights for which the Italian-Americans are so famous. The phrase appears on the front cover of the information bulletin provided by the Naval Support Activity, Naples. This booklet is designed to acquaint you with the area — its people, climate, living conditions, etc., and to assist you in becoming an errant American in a foreign land. Reading through this booklet, your first impressions are soon modified and you come to the realization that this part of Italy is not so highly sophisticated as you had imagined. Although the local water is potable, little, if any, of the local food can be eaten with impunity unless it is subjected to thorough cleaning, chemical treatment or cooked to the well-done state. Local lettuce, for example, must be broken apart and each leaf cleaned to remove gross contaminants, then soaked in a chlorine solution for 30 minutes prior to use. Crisp lettuce becomes but a fond memory. Shellfish, such as clams and mussels, are not recommended even after thorough cooking. These two delicacies adorn many of the pizzas in a land where such pasta is sold by the meter. These culinary precautions are necessary because of the high incidence of infectious hepatitis and other diseases which are attributed to the following conditions:

1. Shellfish grow abundantly near sewer outflows and other contaminated waters.
2. Lettuce, potatoes and root crops are grown in or close to soil which is heavily contaminated.
3. Modern food handling techniques are almost unknown.

Living in this environment will impose emotional strain on many and will produce medical problems seldom seen in the United States. This, in turn, will be reflected in the practice of pharmacy in this area.

Historical Background

The Navy established its first shore-based medical activity in the Naples area during the latter months of 1951 when the personnel and material from the U.S.S. Adirondack moved ashore to establish the Headquarters, Support Activity, Naples. To augment the capabilities of this dispensary and to provide for an increasing number of military and their dependents, a 50-bed infirmary was commissioned in March 1952. In March 1954, the infirmary was moved to a remodeled building in another part of Naples, all medical services were centralized within this structure, and the dispensary was decommissioned. This building had a 100-bed capacity and was later designated the U.S. Naval Station Hospital, thereby becoming a department of the U. S. Naval Support Activity, Naples. In July 1965, construction began on a new eight-story, reinforced concrete structure on the slopes of a volcanic crater within the city limits of Pozzouli, a suburb of Naples. The new hospital was occupied in October 1966; it became a separate command in July 1968 when it was commissioned as the U.S. Naval Hospital, Naples. The Naval Hospital provides medical support for 13 major commands in the area representing approximately 6,000 personnel. It also provides support for other smaller naval medical activities in Italy representing an additional population of 4,000. These numbers include all military (Navy, Marine Corps, Army, Air Force, Coast Guard) and their dependents, certain U.S. civilians and their dependents, and several retired military members and their dependents who live in the Naples area.

Pharmacy Support

Prior to August 1967, pharmaceutical services for the shore-based medical activities in Naples were provided by senior hospital corpsmen or by pharmacy technicians. The technicians were trained by the Navy at one of their two pharmacy schools. This specialty training consisted of eight months of intensive study in inorganic and organic chemistry, pharmacology, principles of pharmacy, pharmacy administration and other related subjects. With this background, the pharmacy technicians were able to provide adequate pharmaceutical services but they were naturally limited,

*Former member of the staff at U.S. Naval Hospital, Naples, Italy.

U. S. Naval Hospital, Naples, Italy

by training and experience, to routine dispensing and simple compounding procedures. As the medical support mission in Naples grew, it became apparent that a more extensive pharmaceutical service must be provided. Such an expansion would require the services of a graduate registered pharmacist. Coincidentally in 1967, the Pharmacy Section of the Navy's Medical Service Corps was expanded from approximately 40 pharmacy officers to more than 100. These pharmacy officers were graduates of accredited pharmacy schools and were registered in one of the 50 states. Several had advanced degrees and many had hospital pharmacy experience. In 1967, a billet for a pharmacy officer was established in Naples and the expansion of pharmaceutical services was begun.

Supply Problems

Training and experience, coupled with good intentions, are usually sufficient for the implementation and continuation of good pharmaceutical services. However, there is one ingredient necessary to make this system work — drugs!! Drugs used by the Naval Hospital were provided by the Supply Depot in Norfolk, Va. Dock strikes, unscheduled sea transportation, customs, and a myriad of other complications made it impossible to keep an adequate inventory of drugs. Routine items could be expected from six weeks to three months after their date of order. Usage rates, ordering cycles and other standard supply techniques were useless with this unpredictable supply system. Routine items became "emergencies." The Army and Air Force hospitals in Germany were able to provide assistance in the face of some drug supply problems, but could not, and should not, be expected to continually provide support. Drugs received from this source were transported via the patient air evacuation system. Patients requiring specialized treatment were flown from Naples to the larger Air Force and Army general hospitals in Germany twice a week. The time required to deliver drugs could vary from one to three days depending upon the departure dates of the air evacuation flights. On occasions when the drug was needed immediately local procurement became necessary.

Local Procurement

Local procurement, although readily accessible, opened up a Pandora's Box of new and vexing problems. Identification of available drug products and manufacturers in this unfamiliar environment poses quite a challenge for the American pharmacist. Recalling the warnings and admonitions expressed in the information booklet concerning sanitation, food products, etc., one is naturally inclined to ponder upon the techniques used in drug manufacturing. Many American companies have been guilty of poor quality control and substandard manufacturing techniques. How do

local companies compare? Several pharmaceutical companies, particularly those located in Milan, have been inspected by a military representative of the Defense Personnel Support Center. These inspections were conducted in response to a request by these companies to be prime producers or bulk suppliers of drugs for use throughout the military services. But these companies represent a small number of the total group of drug manufacturers in Italy.

The Italian Physician Desk Reference is called the "L'Informatore Farmaceutico." This reference book is published annually and contains sections similar to our PDR. Part One consists of an alphabetical listing of the drugs with therapeutic sections (Gruppo Terapeutico), such as antihistamine agents (Antistaminici), in the proper alphabetical sequence. Part Two contains a listing of parapharmaceuticals such as syringes, deodorants, depilatories, perfumes, thermometers, and dietary products. Part Three provides an alphabetical listing of manufacturers and their products, including most of the major American drug companies. Some of the products are listed by name in English, others are listed in Italian and appear unfamiliar. The similarity of Latin terms, indicated sizes and strengths can usually alert one to the form of the medication. Tavolette (tablet), confetti (sweetened), sciroppo (syrup) and gocce (drops), required further translation with the aid of an Italian-American dictionary. In the manufacturers' drug list, the names of several of the items are unfamiliar but the specific strengths indicated suggest well-known products. To determine the exact contents of the medications, one must refer to Part One of the reference book. An example is listed below:

"DOLOXENE (1277 Lilly - Sesto Fiorentino) a-d-4-dimetilamino-1,2-difenil-3-metile-2-propionoxi-butano cloridrato (Dextro-Propoxifene cloridrato, Lilly); dolori muscolari e traumatici, neoplasie e malattie vascolari, mal di testa, emicrania, dolori mestruali e dismenorrea, dolori di parto; 32 mg ogni 4 ore o 65 mg 3-4 volte al di:

20 capsule 32 mg flac. 825
20 capsule 65 mg flac. 1380."

In the example cited, the generic name of the product facilitates identification of the drug as dextropropoxyphene hydrochloride. Its use and recommended dosage also help to confirm the identification. This particular medication is available in 32 mg and 65 mg strengths in a small bottle (flac.) of 20's for 825 and 1380 lira respectively. The dollar to lira ratio fluctuated almost daily but was usually between 620-625 lira per dollar.

In addition to purchasing drugs locally to maintain adequate supplies, the pharmacy was also called upon to identify medications that were prescribed by Italian physicians. In some cases, generic names were shown (as in the above example) and could be related to American drugs, but more frequently only the chemical names were listed. Identification under these circumstances called for an exact translation from an Italian chemical name to a chemical structure which would be more readily recognizable. Armed with the American Hospital Formulary Service and a background in pharmaceutical chemistry, one would attempt to identify these foreign drugs. If unable to relate the drug to an American product, it was usually possible to assign it a therapeutic classification. Many Italian drugs are combination products. Almost all contained vitamins and the preferred method of administration was parenteral. Suppositories followed a close second and chloramphenicol prescribed by this route was frequently encountered.

Another service provided by the Naval Hospital was to assist the Italian-Americans visiting Italy. Many arrived in this country without an adequate supply of medications and turned to the naval hospital for medical assistance. The Status of Forces Agreement between Italy and the United States specifically limited the scope of the Naval Hospital's medical services. Visitors from other countries, including the United States, were required to use the services of the International Hospital in Naples. The Naval Hospital was only authorized to render emergency treatment. The American visitors were, however, provided a reference service. The L'Informatore Farmaceutico was consulted and the Italian names of equivalent American products were provided to those requesting assistance.

Conclusion

Although supply problems created many complications, they also created an opportunity to resurrect an old skill — a background in pharmaceutical chemistry. The proponents of the theory that a pharmacist is overtrained for his function probably fail to consider that these situations do arise. Undergraduates frequently question the value of unrelated courses, such as physics, in the overall pharmacy program but later may come to realize the necessity of logical thinking in everyday life. These courses form an integral part of the total pharmacist's education and immeasurably increase his "worth" on the medical health team. Upon departing Italy, as one says "Arrivederci Napoli," one might appropriately add "Multo Grazie" for the extra service you were required to render. It's gratifying to know that other skills besides counting and labeling must be used in providing a more responsive pharmaceutical service.

RUPTURE OF A HEMANGIOMA OF THE LIVER ASSOCIATED WITH TOXEMIA OF PREGNANCY*

*By LCDR Robert K. Heistein, MC, USNR;** Mervin Binder, M.D.* and; Edward Roth, M.D.**

Hepatic rupture associated with toxemia of pregnancy is a relatively rare complication of pregnancy. According to a review of the subject in 1965 by Hakim-Elahi, there were only 43 cases reported in the literature. Since that time three more cases have been reported by DeHaan, Touloukian and Ferrer, and Dodson and O'Leary. However, only one case of hepatic rupture secondary to hemangioma of the liver was reported.[2] An additional case will be presented in this paper as well as a brief review of the recent literature.

Case Report

M.J., a 26-year-old married Negro female, gravida 4 para 3, was at 28-weeks gestation when she was admitted to the hospital on May 26, 1969. Her last menstrual period was October 21, 1968, and her EDC was July 28, 1969. She had an uneventful prenatal course until the day of admission, when she was seen in her obstetrician's office with a 10-pound weight gain during the past two weeks, 4 + albuminuria, and a blood pressure of 170/100. She was also complaining of severe epigastric discomfort.

In addition to the above findings, her temperature was 100.2; pulse rate was 80/min., and respirations were 20/min. The abdomen was soft with slight epigastric tenderness. The fundus was palpable midway between the xiphoid and the umbilicus. The fetal heart tones were regular at 144/min. The cervix was thick and closed and the vertex was palpable at -2 station. Membranes were intact.

On admission, the patient was placed at complete bed rest and all appropriate laboratory studies were started. She received magnesium sulfate, 2 grams I.V. and 8 grams I.M. The patient was also given morphine sulfate, 0.016 grams I.V. for sedation. An intravenous infusion of 500 cc 20% glucose/water was begun and was followed by 1000 cc 5% glucose/water. Hemoglobin was 12 gms./100 ml.

Blood pressure response to this therapy was good. Within three hours, the blood pressure was 150/90 and her output was 600 cc. She was comfortable, well sedated, and no longer complained of any epigastric distress.

Approximately ten hours after admission the patient suddenly complained of severe epigastric distress and became cold and clammy; no pulse or blood pressure was obtainable. However, she never lost consciousness. No fetal heart could be heard. Positive findings were confined to the RUQ of the abdomen which was tender to palpation. This tenderness extended to the right flank. Hemoglobin was 7.5 gms./100 ml. Blood transfusions were begun.

The patient was immediately taken to the operating room. The preoperative diagnosis was internal hemorrhage secondary to a ruptured viscus, dissecting aortic aneurysm to be ruled out. She had received three units of whole blood by the time the laparotomy was begun and her blood pressure was barely palpable at 30/0. Upon entering the peritoneal cavity, 500 cc of unclotted blood were found free in the abdominal cavity. A huge hemangioma was situated in the right lobe of the liver, occupying almost the entire inferior surface behind the gall bladder. Beneath the capsule anteriorly, across the dome, around the lateral aspect of the liver, was a huge subcapsular hematoma measuring up to four cm in thickness. The capsule had torn at one point adjacent to the gall bladder. Free blood was entering the peritoneal cavity from this rent. The hematoma was evacuated and large Oxycel*** pads

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**Dr. Heistein is presently affiliated with the Dept. of Obstetrics & Gynecology, Naval Hospital, Patuxent River, Md. 20670.

The opinions expressed herein are those of the author and cannot be construed as reflecting the views of the Navy Department or of the naval service at large.

***Parke, Davis & Co., Detroit, Michigan 48232.

were placed across the oozing areas of the liver to control bleeding.

With the hemorrhage controlled, attention was then turned to the fetus. A classical cesarean section was performed and a stillborn infant was delivered. The uterus was closed in the usual fashion. A tubal ligation was also performed. Two rubber tissue drains were placed in the abdomen, one over the surface of the liver and one beneath the gall bladder. The hemangioma was not resected because of its massive size which would have required a right hemihepatectomy.

The patient received a total of 11 units of whole blood during surgery and in the 48-hours following.

The postoperative course was slow and complicated by a subphrenic abscess which was drained in the operating room on the 25th postoperative day. The subsequent course was favorable and the patient was discharged in good condition on the 38th postoperative day.

Comment

Although rupture of the liver as a complication of pregnancy is rare, it is essential that the clinician recognize its characteristic picture if maternal mortality is to be avoided. The only patients who have survived this catastrophic event are those who have been explored surgically.[11]

Abercrombie in 1844 was the first to describe this entity. The characteristic clinical picture is that of a 35-year-old multipara who is in the 3rd trimester of pregnancy.[6] Toxemia is present in 80% of cases, with edema, hypertension, and albuminuria. Eclamptic convulsions are present in 28% of patients. Epigastric pain or discomfort is the prodromal sign in 97%. Shock complicates 94% of cases. Abdominal distention and tenderness are also present.[11]

The preoperative diagnosis is wrong in most cases. The most common preoperative diagnosis is rupture of the uterus.

It has been postulated that the hyperemia of the liver which occurs during pregnancy (especially if it is complicated by toxemia) predisposes the liver to rupture.[11] The pathogenesis of this entity is characterized by the rupture of a portal venule which leads to an intrahepatic hemorrhage. This is followed by the formation of a subcapsular hematoma as a result of local necrosis of liver tissue. When the hematoma reaches sufficient size, Glisson's capsule ruptures and the blood is free to flow into the peritoneal cavity.

Dodson and O'Leary have quoted Devic and Beriel as saying that in traumatic rupture of the liver, the hemorrhage is the result of the rupture. However, in the type of rupture described in this paper, which they call spontaneous rupture, the hemorrhage causes the rupture. The extensive hematoma dissects the capsule from the liver parenchyma finally causing rupture of the capsule and hemorrhage into the abdominal cavity.

Several authors have tried to implicate trauma as the precipitating factor in this sequence of events.[4,6,7,8,11] It is obvious that gross trauma is not involved. These authors are referring to the trauma of active labor, oxytocic induction, transfer from stretcher to the delivery table, eclamptic convulsions, etc. If trauma or anything which raises intra-abdominal pressure did not occur, then some other predisposing factor such as hemangioma,[2] hepatoma,[12] or amebic abscess[12] was present.

The overall maternal mortality is 75%. In those undergoing surgery the maternal mortality is 55%.[11]

Kramish, et. al., advocate the following methods for the control of the hemorrhage: packing the liver with Oxycel or other similar material; electrocoagulation; application of methyl alpha cyanoacrylate to the liver; suturing of the laceration with blunt, non-cutting needles; and drains.

Yen has reported two cases which were not associated with toxemia. One was predisposed by a hepatoma and the other was precipitated by an amebic liver abscess.

Several cases were reviewed by Salzmann and Malkary. They noted that several of the survivors were those patients in whom the rupture of the liver was discovered post partum. "It may, therefore, be speculated that since toxemia is the causative agent, the post partum patients improved when they were correctly treated . . . . It is assumed that termination of pregnancy is the major factor in treating these patients for hepatic hemorrhage."

Summary

1. The second reported case of rupture of a hemangioma of the liver complicating toxemia of pregnancy is presented.

2. This patient represents the 47th reported case of hepatic rupture in pregnancy and is the 15th reported survivor of this event.

3. This catastrophic complication of pregnancy presents a characteristic clinical picture including toxemia, abdominal distention, epigastric pain, and shock, especially in a multiparous patient in the 3rd trimester.

4. Immediate laparotomy offers the only chance for survival. No survivors have been reported among those not undergoing surgery.

(Continued on p. 32)

THE GASTROENTEROLOGISTS' CORNER

GASTRIC ULCERS ARE DIFFERENT!

By CDR Gerald T. Roling, MC, USN; Gastroenterology Branch, Medical Service, Naval Hospital, Philadelphia, Pa.*

Gastric ulceration presents to the clinician a problem of wider scope than that posed by the more commonly encountered duodenal ulcer disease. The diagnostic challenge is created by the possibility that the gastric lesion is in actuality an ulcerating malignant tumor. It has been suggested by some that gastric ulcer represents a surgical disease and should be so treated.[1] Such would be an acceptable approach were it not for a surgical mortality of approximately two percent for gastric resection, and a morbidity of ten percent in which the patient is more symptomatic postoperatively than preoperatively from his primary disease.[2] Because of the "fear" of mistakenly diagnosing a malignant ulcer as benign, radiographic reports frequently add to the confusion: "The ulcer appears radiographically benign, however, malignancy cannot be excluded."

The problem of gastric ulcer is best approached through cross consultation with the radiologist, surgeon, internist, and when available, the very helpful examination by a gastroscopist. Only by this multidisciplinary approach can we hopefully select the patient whose gastric ulcer represents a malignant tumor. Because of the varied and sometimes unusual treatment regimens that some patients have undergone prior to their referral to this hospital, a clinical review should prove helpful in providing guidelines for the evaluation, treatment, and follow-up of patients with gastric ulcerations.

Pathogenesis of Gastric Ulcer

There are two schools of thought regarding the pathogenesis of gastric ulcer: first, that peptic ulcers of the duodenum and stomach are similar; and second, that gastric ulcer is not peptic in origin, based on different laboratory test results. Lester Dragstedt, whose surgical philosophy has inspired many, believes that gastric ulcers and duodenal ulcers are caused by the digestant action of acid peptic juice.[3] This concept is supported by the beneficial effect of operations which reduce the quantity of gastric secretion, or by-pass procedures which shorten the time during which acid-peptic juice bathes the ulcer area. Ample laboratory and clinical studies yield results consistent with this view.

The physiologist has demonstrated two stimuli for acid secretion: neural stimulation via the vagus nerve, and hormonal stimulation mediated by gastrin. It has been suggested that duodenal ulcers are usually associated with hypersecretion of gastric juice resulting from neural stimulation while gastric ulcers are caused by hormonal stimulation of gastric juice via gastrin.[3] On this basis, duodenal and gastric ulcer can be related "etiologically" to the acidic and peptic characteristics of gastric secretion, respectively.

If gastric ulcers are to be regarded as peptic, it becomes important clinically to locate the common sites of ulceration. Gastric acid bathes the distal part of the stomach as the gastric contents flow toward the pylorus. The antrum is equipped to protect itself from this acid by mucous secretion. Moreover, the linear nature of the rugal folds would appear to favor faster channeling of the acid fluid over its surface. After implanting spleen and kidney into the gastric wall of dogs, Dragstedt could demonstrate the protective action of saliva, mucus, and food which dilute and neutralize the acid.[3] No digestion of the implanted organs occurred with gastric acid stimulation. If, however, he isolated a gastric pouch and prevented food, saliva and mucus from contacting the pouch, the spleen or kidney then implanted in the pouch wall was soon digested away. From this it may be assumed that the gastric mucosa enjoys a somewhat protected milieu if it is not bathed by acid-peptic juice for any prolonged period of time, and is in continuity with the esophagus and mucus-secreting antral mucosa.

Where then is the vulnerable area of stomach in which gastric ulcers are most likely to form? In 1865 Brinton noted that the majority of gastric ulcers occur

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The opinions expressed herein are those of the author and cannot be construed as reflecting the views of the Navy Department or of the naval service at large.

on, or adjacent to, the lesser curvature.[4] Andrew Ivy and his associates reported that they occur on the lesser curvature in the region of the angularis incisura, or proximal to it.[5]

In 1959 Dr. Minoru Oi and his co-workers demonstrated that ulcerations tend to occur at mucosal borders that separate cell types.[6] An intermediate area was defined at the angularis incisura where the fundic and pyloric gland mucosa merge. In this circumferential border zone, averaging only 0.19 cm wide on the lesser curvature and 0.28 cm on the greater curvature, 96.4% of gastric ulcers occurred. They considered that a "locus minoris resistentiae" existed.

Recently these authors have presented additional interesting findings that relate to this mucosal susceptibility.[7] Motility disturbances have been incriminated as an additional cause of gastric ulcer. Dr. Oi, after mapping out the ulcer mucosa, further examined the underlying muscle bundles. As shown in Figure 1A a border circular muscle bundle can be located near the angularis incisura. In the vicinity of the border circular muscle, 93.6% of 158 gastric ulcers occurred. By comparing the mucosal and the muscle bundle ulcer maps, it was possible to establish whether or not the fundic-pyloric mucosal border zone crossed the circular muscle fibers. (Figure 1B) In gastric specimens without gastric ulcer, this crossing occurred 48% of the time. In gastric specimens with gastric ulcer, however, all but one were of the crossing type, the exception being one gastric ulcer that appeared on an ectopic island of pyloric glands in the fundus. The relationship observed suggests that gastric ulcer occurs at crossing areas, where kinetic strain due to gastric motility is great. The focal area containing the majority of gastric ulcers is limited to 5% of the total mucosal area (excluding the rugal folding) and to 11% of the total muscle area. Suffice it to say that gastric ulcer is found 95% of the time in a mucosal and muscle zone where kinetic strain and mucosal susceptibility enhance the erosive action of acid peptic juice.

This small area of gastric mucosa, however, has the benefit of some safeguard features. Dr. Rene Menguy in addressing the question, "Why does the stomach not digest itself?" offers an answer given several years ago by Claude Bernard.[8] He stated that the layer of mucus covering the surface epithelium acts as a "porcelain shell" to protect the vulnerable epithelium from the erosive gastric contents. The alkaline mucus produced by the glands of the prepyloric antrum is composed of a mucoid glycoprotein fraction, a protein fraction, and a third ill-defined small molecular weight polypeptide fraction.[8] The glycoprotein fraction imparts to mucus its characteristic viscosity. Because of this viscosity the mucus adheres to the surface epithelium, resisting breakdown by the peptic enzymes. As the antral pH drops, the prepyloric glands increase their output of mucus and also raise the concentration of the viscid glycoprotein fraction. Production of this mucus appears to result from the direct contact of acid with the epithelial cells rather than via the vagus nerves. It can

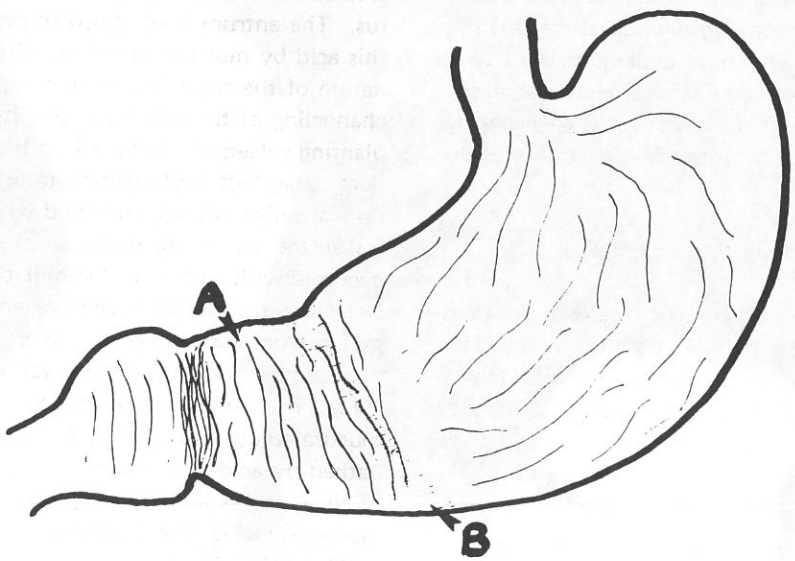

Figure 1. Circular muscle bundles are depicted by the lines labeled "A". Muscle bundles are seen to cross the mucosal intermediate (border) zone labeled "B".

be demonstrated that antral pouches innervated by the vagus nerve do not increase mucus secretion in response to vagal stimulation; if acid comes into direct contact with the mucosa, however, increased mucus secretion results. Decrease in mucus production therefore can render the mucosa susceptible to acid injury, and such may be the case in steroid induced ulcerations.[8]

The Clinical Setting

In the evaluation and treatment of patients with gastric ulcer it is convenient to classify patients as follows:

Group 1. Patients who develop gastric ulcer secondary to ulcerogenic medication, e.g. Butazolidin, reserpine, steroids, etc.

Group 2. Those who develop gastric ulcer as a complication of duodenal ulcer disease with gastric stasis.

Group 3. Those who present terminal extragastric disease, e.g. uremia, metastatic disease.

Group 4. High risk patients who are candidates for recurrent gastric ulcers. The incidence rate of severe complications with recurrent gastric ulcer is particularly high.

Group 5. Patients in whom no specific etiology for gastric ulcer is discerned. Prompt and complete healing is expected in these patients who are sufficiently healthy to chance a recurrence.

By clinical assessment it is possible to classify the patient in one of the above groups. First, a malignant ulceration is tentatively ruled out: At the Naval Hospital in Philadelphia, four study techniques are employed in reaching this status; X-ray, gastroscopy with biopsy, gastric cytology, and gastric acid analysis.

X-ray: As demonstrated in Figure 2, the typical benign ulcer appears as a barium filled out-pouching of the smoothly contoured gastric wall. A radiolucent shadow across the apparent base of the ulcer ("Hampton's Line") suggests that the ulcer is benign. This shadow is caused by proliferation of normal mucosa over the ulcer edges in benign cases, whereas a malignant ulcer frequently occurs as an ulceration in a tumor mass which deforms the smooth contour of the gastric wall. The presence of a Hampton line however does not rule out a malignant lesion.

As mentioned earlier the site of the ulcer is important. A mid-lesser curvature gastric ulcer is the most common and also the most frequently benign. A mid-greater curvature ulcer is also most often benign, but prompts added concern because this is an atypical area for benign ulcer lesions. Where then do malignant ulcers occur? They occur anywhere in omach and

Figure 2. A gastric ulcer on the lesser curvature is identified by the arrow. A radiolucent line (Hampton's Line) may be seen at the base of the ulcer.

it is this fact that necessitates thorough evaluation of each ulcer. Some feel that there is a slightly increased frequency of malignant ulcers in the prepyloric antrum.[9] Of clinical importance is the better survival rate associated with the more distal gastric malignancies which are more amenable to surgery.

Gastroscopy: Endoscopically the "typical benign ulcer" is located on or in the immediate proximity of the angularis incisure. It is usually sharply demarcated and has a white-yellow homogeneous necrotic base (Figure 3). Irregularity, mounding of edges, and a dirty necrotic base suggest neoplastic change. Four quadrant biopsies of the ulcer edge are performed if technically possible.

Cytology: Gastric cytology is performed by a forceful saline lavage after fluoroscopic placement of the tube tip near the ulcer area. Some centers advocate using chymotrypsin lavage to exfoliate more cells. Gastric cytology may reach 95% accuracy in departments attentive to proper technique and interpretation.[10] Brush cytology of the ulcer at time of gastroscopy is a more recent effort to increase the cytological accuracy.

Gastric Analysis: Gastric analysis with Histalog may introduce confusing information. Although 50-80% of patients with gastric ulcer are notoriously credited with Histalog-stimulated hypoacidity, nevertheless a significant number may have normal or even elevated acidity. The only reliable significance of gastric acid determinations is that anacidity with stimulation is a clue to malignancy. A large group of gastric ulcer patients, therefore, occupy the frustrating overlapping range of normal-hypoacidity.

Benign or Malignant?

This is the prime consideration in managing the patient with a gastric ulcer. What are the chances of being wrong after an ulcer is judged benign on the basis of initial X-ray, gastroscopy, cytology, and gastric analysis studies? In a literature review of 8,618 cases of gastric ulcer, Eddy Palmer cited a 9.2% error in diagnosis.[11] This review, however, encompassed 30 years. The more widespread use of flexible fiberoptic gastroscopy and properly performed gastric cytology, coupled with gastric analysis and radiographic studies should drop this diagnostic error to one or two percent, a figure equaling the surgical mortality for gastrectomy in the best centers.[2]

The frequency rate of recurrent gastric ulcer, however, is usually around 50%, suggesting that surgical consideration should be given every patient with a gastric ulcer. Herein lies the value of endeavoring to classify each patient on a practical clinical basis as

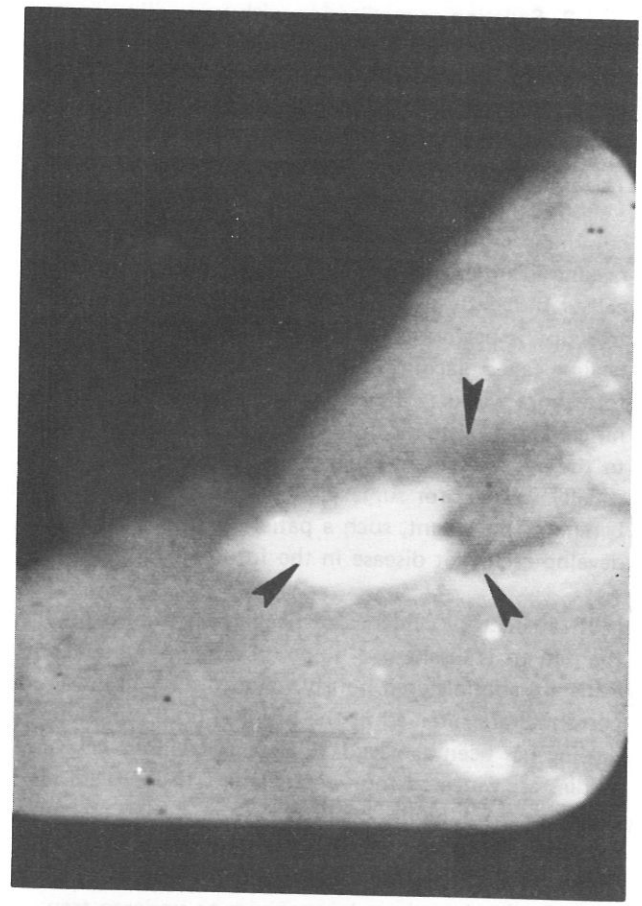

Figure 3. The lesser curvature gastric ulcer demonstrated radiographically in Figure 2 is seen on gastroscopy to be a punched out lesion just proximal to the veil-like angularis incisura.

previously discussed. An elderly man who has bled from a gastric ulcer cannot be equated with a young man who has not bled from his ulcer and is in otherwise good health. Mortality attributable to complications of recurrent gastric ulcer disease will be greater in the elderly.

Treatment of Gastric Ulcer

All four modalities (X-ray, gastroscopy, cytology, gastric analysis) are employed initially. If the benign nature of the lesion is questioned by the radiologist, gastroscopist, or cytologist, surgery is strongly considered when the patient's condition is stable. If conflicting evidence fails to resolve the diagnostic uncertainty, the rate of diagnostic error may rise to 20-25%. Should no evidence of malignancy occur during the initial evaluation, which should usually take no more than three or four days, the following steps are taken:

1. Hospitalization
2. Ulcer diet, restricted to milk, scrambled eggs, creamed soups, etc. (Sippy or Ulcer Diet No. 1 or No. 2)

3. Sedation or medication with tranquilizer agents if necessary to ensure physical and emotional rest

4. Liquid antacid administered hourly while awake. Some patients are awakened at 0100 and 0400 for milk and antacid medication.

Following two weeks of treatment, X-ray, gastroscopy, and cytology studies are repeated. At least 50% healing is anticipated radiographically and gastroscopically. If slightly less than 50% is observed, serial gastroscopy is performed at weekly intervals until full healing takes place; this usually occurs within two to four more weeks. The patient who fails to present significant improvement in his ulcer after strict adherence to the above regimen for a period of two weeks, is usually referred for surgery. Whether the lesion proves benign or malignant, such a patient would most likely develop recurrent disease in the future.

If satisfactory evidence of healing is demonstrated, the patient is discharged home on a bland diet and antacids are administered hourly. Active duty military personnel are retained in the hospital until complete healing has been achieved. Upper gastrointestinal X-ray studies are repeated four weeks later. If complete radiographic healing has occurred, X-ray studies are subsequently repeated at 3, 6, 9, and 12-month intervals. These serial studies are recommended because malignant gastric ulcers have been shown to undergo transient healing, and the malignant nature of the lesion will become manifest within that first year.

Note that anticholinergic drugs are not used. The gastric stasis associated with their use may impede gastric emptying and prolong healing by causing release of gastrin, thus stimulating further acid production. This mechanism is thought to also play some role in the production of gastric ulcers in patients with coexistent duodenal ulcer disease. Not infrequently, gastric ulceration is seen in patients who present duodenal bulb deformity from prior duodenal ulcer disease. This group of patients has a significant gastric ulcer recurrence rate since the primary problem of gastric stasis secondary to duodenal disease and resulting gastric outlet obstruction, receive no definitive treatment. Individualization in the management of each case is needed, however, we lean toward surgical disposition in these patients.

Summary

Gastric ulcer should be managed differently from duodenal ulcer disease. The possibility of malignant gastric ulcer necessitates a thorough evaluation with X-ray, cytology, gastroscopy, and gastric acid studies. The percentage of misdiagnosed malignant ulcers, by employing competent methods of assessment, may decrease to one or two percent, a figure comparable to the operative mortality for simple gastrectomy. At least a one-year follow-up of these patients with quarterly X-ray studies is recommended. Cross consultation between the radiologist, surgeon, and internist should be employed. As suggested by Taylor,[12] "Every case of gastric ulcer must . . . be treated to a conclusion."

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MARINE CORPS MEDEVAC/SAR* DEVELOPMENTS

From the Office of the Medical Officer, U. S. Marine Corps Headquarters, Washington, D. C.

UH-1N Helicopter

In April 1971 the Marine Corps took custody of its first UH-1N helicopter at Marine Corps Air Station, New River, Jacksonville, North Carolina. This first twin engine Huey looks similar to the present UH-1E but with a considerably enlarged cabin that accommodates 13 troops or 6 litters plus one corpsman. In cases of extreme emergency, a Stokes litter can also be attached to the skids on each side. It is planned that the UH-1N will take over the bulk of the medevac missions once the squadrons are built up from the present level of nine UH-1Ns on hand, to a level sufficient to support a force of six light helicopter squadrons. The high degree of reliability and survivability inherent in the twin engine configuration, large sliding doors on both sides of the aircraft, excellent crew visibility, and an airspeed capability of 120 knots, makes the UH-1N an excellent vehicle for the medevac mission. For other rescue operations, a 600-lb cable hoist may be attached in a short period of time. The side loading capability within easy view of the crew, vice the rear loading configuration of the CH-46 series, will require less time to

(Continued on p. 47)

*Search and Rescue

The UH-1N Helicopter. Note enlarged cabin.

NAVY CLINICAL INVESTIGATION PROGRAM

A Clinical Investigation Program (CIP) has now been established. The program became operational on 1 July 1971 and will support approved investigational studies which are not specifically military mission oriented. Use of the title, Clinical Investigation Program (CIP), has been deliberate to distinguish this from military mission oriented research which is now, and will be in the future, supported by RDT&E (Research, Development, Testing and Evaluation) appropriations. As a patient care related function, the CIP will be funded through an addition to the O&M (Operating and Maintenance) budget. Funds will be programmed for this purpose.

Significance

Under the CIP funds can now be made available to support investigation of all clinical conditions which are of significant concern in meeting the health care needs of the entire naval community, including active duty personnel, dependents, retirees and their dependents, and other eligible persons. The climate for future medical/dental care and training should be greatly enhanced by this development, for the CIP literally expands our concern beyond the immediate bounds of Defense Department requirements, to encompass clinical care and treatment of all our patients. As physicians, our philosophy and thinking has always been instinctively patient oriented. Now a dynamic tool for organizing, supporting and funding high-quality clinical efforts has been provided. Inspired by the great potential for enhanced medical productivity, those responsible for directing the Navy CIP are already hard at work. Clinicians are urged to participate in, and benefit from, this newly activated system.

Policy and Objectives

Clinical investigation is an essential component of an optimal health care system. By organized inquiry into clinical health problems, the CIP has the following purposes:

(1) To achieve continuous improvement in the quality of patient care.

(2) To provide experience in the mental discipline achieved by participation in such organized inquiries, and to provide experience for personnel who will ultimately be teaching chiefs of service in naval hospitals and/or medical specialty consultants.

(3) To maintain atmosphere of inquiry because of the dynamic nature of the health care sciences.

(4) To maintain high professional standing and accreditation of advanced health care, education and training programs.

The effectiveness of this program is to be monitored by the extent to which it advances the quality of health care rendered in naval medical activities, as judged by accepted professional standards, including statistical health data, accreditation evaluations, inspections and surveys, and such other criteria as may be developed to monitor health care and the professional competence of health care personnel.

Organization and Functions

Under the cognizance of the Chief, Bureau of Medicine and Surgery (BUMED), the CIP will be administered and coordinated by a Clinical Investigation Control Center (CICC) to be established by BUMED at the National Naval Medical Center (NNMC), Room 217. The Director is George H. Reifenstein, M.D., BUMED Code 10, Technical Director of Clinical Research and Medical Education. His staff will include military representatives from BUMED. (Until his office space at NNMC is renovated, hopefully within nine weeks, Dr. Reifenstein is temporarily located in BUMED, Room 1101.)

The CICC is responsible for the following functions:

(1) Serves as the management focal point for the CIP.

(2) Establishes and promulgates the policy which will guide naval medical activities in the conduct of clinical investigations other than those efforts under the purview of the Navy Medical Research and Development Program (BUMEDINST 3900.3 series).

(3) Determines and promulgates relative priority decisions pertaining to the various clinical investigation requirements submitted by naval medical activities.

(4) Determines, directs, and executes criteria and procedures for evaluation and approval/disapproval of the merit and design of clinical investigations which are not under the purview of BUMEDINST 3900.3 series.

(5) Ascertains, programs and supports total resource needs through Chief, BUMED, in consultation and cooperation with the Assistant Chief for Planning and Logistics (BUMED Code 4).

(6) Approves allocation of resources to the eligible medical activities in consonance with established priorities for the clinical investigation effort.

(7) Monitors the effectiveness of the program.

The Clinical Investigation Review Centers (CIRCs) are designated as follows:

Naval Hospital, NNMC, Bethesda, Md.

Naval Hospital, Boston, Chelsea, Mass.

Naval Hospital, Great Lakes, Ill.
Naval Hospital, Oakland, Calif.
Naval Hospital, Philadelphia, Pa.
Naval Hospital, Portsmouth, Va.
Naval Hospital, San Diego, Calif.

All other naval medical activities will be considered as satellite activities for conduct of efforts under purview of the CIP.

Graduate training hospital commands designated as CIRCs shall each review all clinical investigation proposals originating from professional services within that hospital, as well as those from satellite medical activities. The study proposal with appropriate endorsement will then be forwarded to CICC.

Procedure

Each activity initiating a proposal for a clinical investigation effort shall utilize the Clinical Investigation Study Proposal Format MED-6000-3 if approval and funding under the CIP is sought. (If the originating activity considers the effort to be under the purview of the Medical Department Research and Development Program, the provisions of BUMEDINST 3900.3 series apply.) Satellite medical activities shall forward clinical investigation study proposals to Chief, BUMED (Attn: CICC), via the cognizant CIRC, with advance information copies to BUMED for record purposes.

Each study proposal shall be reviewed by the Research and Clinical Investigation Committee for merit, feasibility, and ethical human utilization considerations where applicable. Consultation opinions from university medical center consultants shall be obtained when indicated. Opinions and recommendations of other in-house boards and committees shall be obtained when indicated; e.g., Pharmacy and Therapeutic Committee, Tumor Board, and Radioisotope Board. The Executive Council of the Graduate Training Committee should comment if a question of ethics and human utilization arises.

The study proposal shall then be forwarded to Chief, BUMED (Attn: CICC), endorsed by the commanding officer with a recommendation for either approval or disapproval. Opinions of cognizant committees, boards, and consultants will be enclosed or summarized in the forwarding endorsement.

BUMED (CICC) will:

(a) Review the clinical investigation study proposal.

(b) Notify the originating activity directly whether the study proposal has been approved or disapproved.

(c) Furnish only information copies of Bureau action to the cognizant CIRC.

(d) If approved, furnish the originating activity appropriate funding data and expenditure reporting requirements.

(e) Assign a permanent Clinical Investigation Study Number to the approved study proposal.

Scientific/Technical CIP Study Reports will be submitted/distributed in accordance with BUMEDINST 3900.4 series. BUMED (CICC) shall be included in the recommended distribution list from each activity conducting CIP studies. An Annual Progress Report is required on each on-going CIP study. The Annual Progress Report shall be forwarded to BUMED (CICC) prior to 1 February. Reprints of published articles shall be included with the Progress Report. Annual Progress Reports should be carefully formulated scientific documents. They will assist the Director, CICC, in ordering priorities within the total CIP.

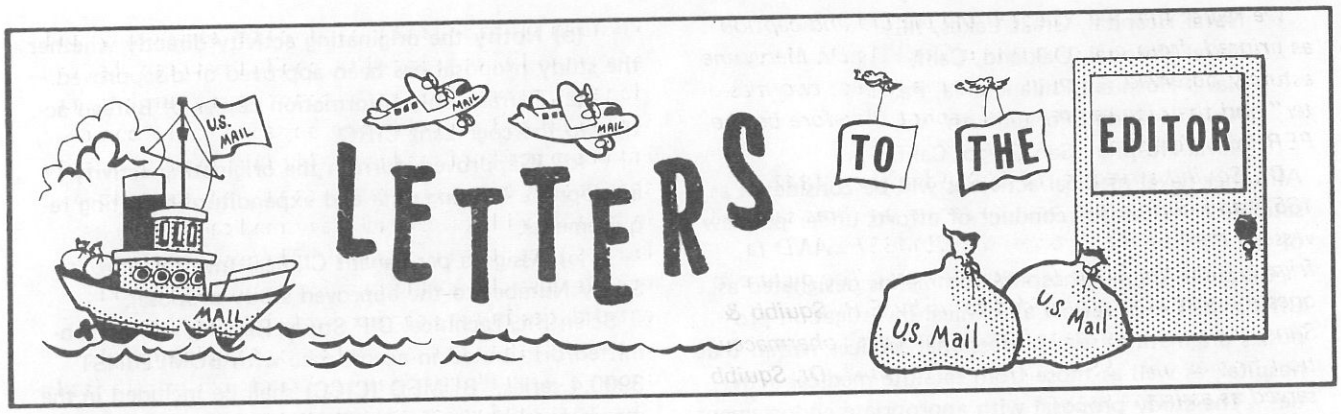
Future Plans

CIP will supplement but in no sense supplant the present RDT&E research funded program. All research and clinical investigation proposals will be reviewed at the local facility level by the Research and Clinical Investigation Committee and referred to either the Research Division of BUMED or CICC for action. Favorable action by CICC will be accompanied by release of the necessary O&M funds to the medical facility. Approval and funding for research studies will remain unchanged.

Long range planning includes not only the funding of an increased number of clinical investigative studies, which are not appropriate for RDT&E funding, in all BUMED command activities, but also eventually funding for staffing of Clinical Investigation Centers (CICs) in certain large hospitals already carrying on graduate medical education. The bulk of the funds will be used by graduate training facilities, but all reasonable requests from Navy Medical Department facilities will receive careful consideration by the CICC.

Plans are underway to convene a Workshop in Clinical Investigation in Oct. 1971, to be attended by appropriate personnel from medical and dental facilities.

References: DOD Directive 6000.4 dtd 7 Apr 1971.
BUMEDINST 6000.4 dtd 17 June 1971.



To the Editor: Your publication U. S. NAVY MEDICINE is one of the best. It helps us who are retired reservists keep in touch. It comes to us at the Veterans Administration Outpatient Clinic, San Diego, where we serve those who have served.

Of particular interest was the article "The Medical Supply System and Field Branch, Bureau of Medicine and Surgery: 120 Years of Service," and its pictures. (April 1971 issue, pp 43-54) Was the ship PERRY (pictured on page 45) called a brig due to a former vessel in that duty being of that class, or had it originally been a two-masted vessel? A brig to my knowledge is a square or ship rigged sailing vessel with two masts only.

Also enjoyed "Glaucoma and Flying," and other interesting and useful articles.

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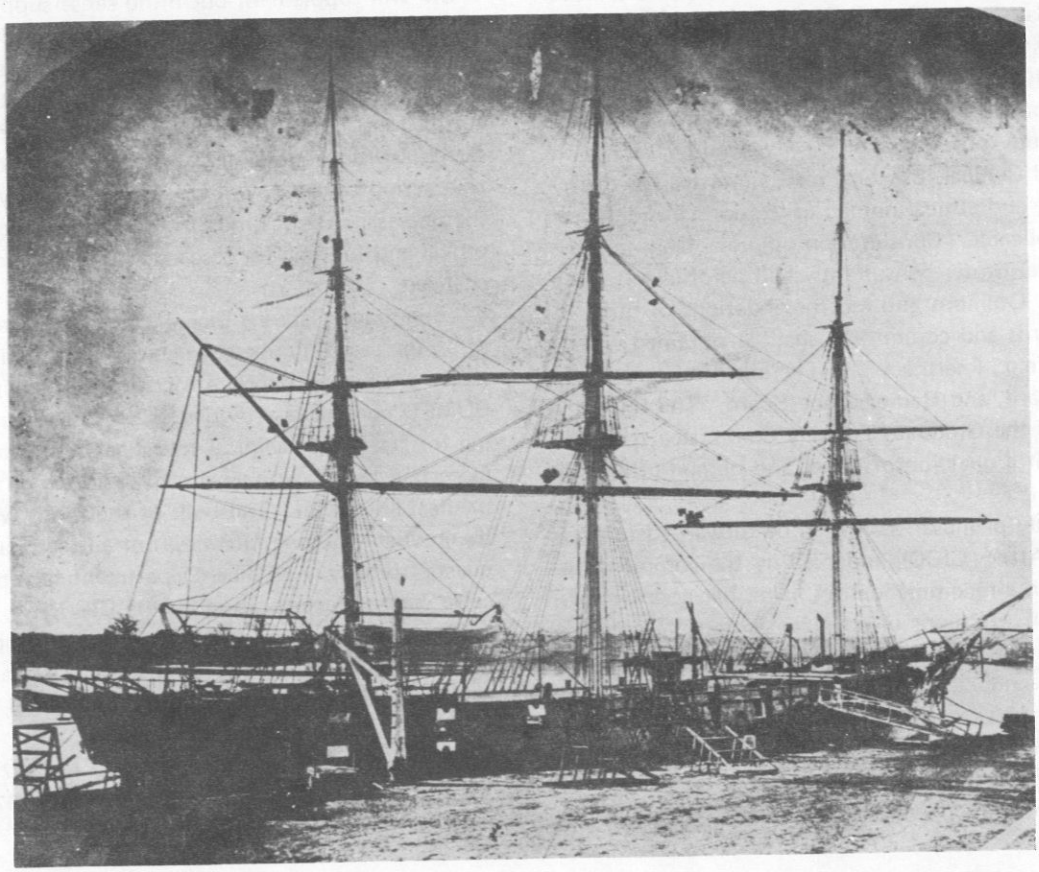


USS Cumberland, launched 24 May 1842 by Boston Navy Yard. Dr. Squibb served as assistant surgeon aboard this frigate, Nov. 1849 - July 1851. (Incorrectly labeled the brig PERRY in the April 1971 issue, page 45.)

We regret that we accepted the picture and caption as printed, from our own office files. As Dr. Mervynne astutely observed, a brig is a "square-rigged, two master" and the picture presented cannot therefore be the PERRY. We erred.

Dr. Squibb served in the U.S. Navy from 1847 to 1857, and during that time he served on three sailing vessels, the PERRY (a brig), the CUMBERLAND (a frigate), and the ERIE (a sloop-of-war). The picture in question was kindly provided to us by E.R. Squibb & Sons, Inc.; and was identified by the latter pharmaceutical firm as the USS Cumberland, in which Dr. Squibb served as assistant surgeon.

CUMBERLAND made her second cruise to the Mediterranean from 1849 to 1851, returning as flagship of the squadron there from 1852 to 1855. On 8 March 1862, she was rammed and sunk in an engagement with the Confederate ironclad VIRGINIA (formerly USS Merrimack) at Newport News, Va.

Our thanks to Dr. Mervynne for calling this to our attention.

To the Editor: I have been associated with the Navy Medical Corps for almost eight years now, first as an Ensign 1915, then a Reserve Unit medical officer, a Navy resident, and for the past three years, as anesthesiologist in a naval hospital. During this period of time I have become less and less certain of the role of a physician in the U.S. Navy. I personally feel that I am a physician primarily and a naval officer secondarily, and in general, I have found little conflict between the two. However, recently I seem to continuously run into authoritative and administrative obstacles to the conscientious practice of medicine. My own sense of priority that patient care and comfort come first, seems to be in conflict with the overall Navy medical scheme, at least as I see it from my level. There seem to be numerous obstacles to the carrying out of patient-oriented duties in a modern and efficient manner. Am I wrong in feeling that renovation of the physical plant should follow *after* modernization of patient care facilities, that administrative reports and conferences should not take precedence over operation of clinics and completion of operating room schedules? Am I alone in finding it increasingly difficult to uphold the highest standards and traditions of the medical profession without conflicting with the traditions of the military service?

I am leaving the Navy this summer, a departure that becomes increasingly easier as the time draws near. I hope my dedicated colleagues who stay will find it possible to provide their military communities with the advances in medical care taking place in the civilian communities, without the great administrative delays built into the Navy medical system.

LCDR Jack Egnatinsky, MC, USN
Annapolis, Md. 21402

(Continued from p. 43)
load wounded and return to the appropriate hospital or aid station.

Weather will cause no delay for UH-1N. Mission equipment permits operation from unprepared takeoff or landing areas under day or night instrument conditions including light icing. In addition to a full range of avionics equipment, the twin Huey's hydraulic boost, force trim, stabilizer bar and easy power management, minimize pilot fatigue under IFR (Instrument Flight Rules) conditions.

The UH-1N, with new solid state SLAE (Standard Lightweight Avionics Equipment) has a selection of more than 5,000 voice channels. At moderate altitudes, the pilot can command a communications link over 8,000 square miles. With the addition of a high frequency radio (provision already installed), communication range can be greatly increased.

AH-1J Helicopter

To further aid the medevac mission, the troop transport helicopters will have the escort and suppressive fire support of the new AH-1J Sea Cobra. Forty-three of these aircraft have currently been delivered. Additional procurement is planned to equip and support a force of three attack helicopter squadrons. This aircraft is considered the follow on to the present AH-1G and will eventually replace that aircraft in the deployable forces. This new armed helicopter, introduced to the Marine Corps forces in February 1971, has twin engine survivability and a Navy-designed armament management system that gives the aircraft the capability of delivering a wide range of ordnance for landing zone support.

VIETNAMIZATION

As the expansion of the Naval Advisory Group parallels redeployment of large numbers of officers and men, the role of our Navy in Vietnamization has shifted to one of advising and assisting. Three prime elements of the program have become increasingly operational.

The accelerated turnover (ACTOV) of U.S. Navy assets to the Vietnamese has made possible the reduction in commitment of U.S. combat sailors in Vietnam. The Vietnamese Navy (VNN) now owns and operates our "Brown Water Navy" craft and coastal surveillance force. The accelerated turnover of logistic (ACTOVLOG) responsibility and assets, employing combined USN/VNN forces of operators and managers to ease the transition, has progressed rapidly and well. A program for achieving coastal surveillance by a Vietnamese system of radar network (ACTOVRAD), will hopefully eliminate the use of our long range patrol aircraft in the future.

The following articles provide a serial view of medical achievement over the past seven months, within the framework of the Vietnamization Program. The three authors have conveyed the posture of our medical mission within the overall context of U.S. involvement in Vietnam, and the three articles are therefore of historical interest. We are pleased to present them, in order of acquisition.

CO-MANNING OF NSF DISPENSARY DANANG

By JO1 Len Churilla, USN. (Photos by PH2 William Donhauser and FN R.M. Tally, USN.) DaNang, RVN, Dec. 18, 1970.

With the arrival of Dr. Nguyen Dieu, LT(jg) in the Vietnamese Navy Medical Corps, the Naval Support Facility (NSF), DaNang's Dispensary takes a giant step forward in the co-manning and eventual turnover of the U.S. Navy's remaining medical facility in Military Region I to the Vietnamese Navy.

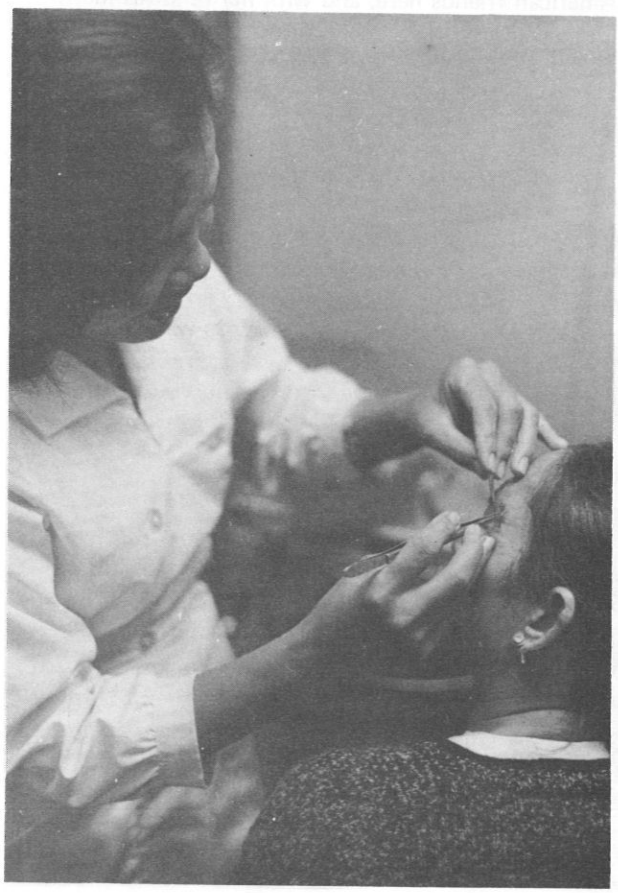
Vietnamese Navy Hospital Corpsman Second Class fills out prescription for patient.

In line with President Nixon's Vietnamization Program and its related reduction of U.S. Navy personnel and functions in Military Region I of South Vietnam, the NSA hospital in the region was closed down on 15 May 1970. This was one of the preliminary steps taken by the former Naval Support Activity (NSA), DaNang, to phase down its operations and become the new Naval Support Facility (NSF), DaNang on 1 July 1970.

When the 600-bed hospital was closed, patients still under care and treatment were moved to other military hospitals in the area, some to U.S. Army hospitals and others to the Naval Hospital Ship SANCTUARY off the coast. Other patients were sent home or to hospitals in other countries.

Portions of the former NSA which were not turned over to the U.S. Army or the Vietnamese Navy on 30 June 1970, are being gradually turned over to the Vietnamese Navy in phases. This includes the only remaining Naval medical facility in the area, the small dispensary located at Camp Tien Sha.

Before the hospital closed, this dispensary was moved to a larger, renovated building and expanded to accommodate a 28-bed ward for emergencies. Physical examinations and medicine are given there, and inpatient treatment for a period up to 72 hours. Patients requiring longer treatment are sent to hospitals in the area or out of the country.



Vietnamese Civil Service nurse removes sutures.

Vietnamese Navy Hospital Corpsman Third Class checks healing of burn on leg of fellow Vietnamese sailor.

At present there are two U.S. Navy doctors, 16 U.S. Navy corpsmen, an ambulance driver, a Medical Service officer, two dentists and three dental technicians. Three Vietnamese women (two civil service nurses and one X-ray technician) were brought from the hospital when it closed to the new dispensary; these women eventually became the core of the Vietnamese medical staff there.

In September three Vietnamese Navy hospital corpsmen arrived. Within two weeks they were diagnosing, screening and treating Vietnamese navy patients. In effect, this was the first link in the Vietnamese Navy Health Care System at NSF DaNang.

During 1971 a Vietnamese dental officer, pharmacist, and several dental technicians will be phased in to complete the co-manning of the dispensary at Camp Tien Sha.

As U.S. Navy corpsmen were departing homeward

without replacements, the Vietnamese Navy corpsmen were assuming primary responsibility for their own men. They have proven their ability in caring for patients, treating common skin rashes, venereal disease and minor injuries, and detecting more serious illnesses for referral to medical officers.

By November 1970 there were 10 Vietnamese Navy corpsmen and three Vietnamese civil service nurses, in addition to the X-ray technician. With the arrival of Vietnamese Navy Dr. Nguyen Dieu on 19 November, co-manning of the NSF dispensary became complete.

In war-torn Vietnam, just as in any country, it takes considerable formal training and experience to become a physician. So it was with 28-year-old Dr. Dieu. The youngest of five children in his family, reared in Quang Nam Province, he attended medical school for seven years; six years were spent at the medical school in the ancient capital city of Hue and one year at the medical school in Saigon. After graduating from medical school in November of 1969, he interned at the hospital in Hue. He was drafted into the Vietnamese Army in April, 1970.

Dr. Dieu received two months of training at the Army Officer Candidate School at Thu Duc and was commissioned as a Second Lieutenant in the Infantry in July 1970. Shortly afterward he attended the Military Medical School at Saigon for three months, studying admission and administrative procedures. He was then commissioned in the Vietnamese Navy and spent a little duty time aboard the Vietnamese hospital ship Han Giang (HQ-401) before reporting to NSF DaNang.

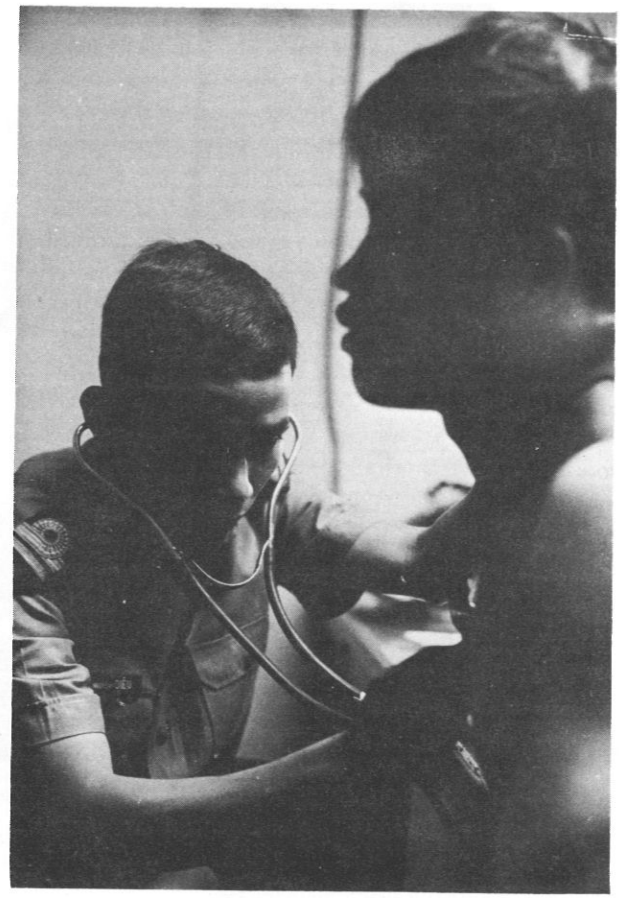
Since arrival in NSF DaNang, Dr. Dieu has been busy getting adjusted, and attending medical conferences here and in Saigon. "This dispensary in DaNang is the first of eight U.S. Navy dispensaries in Vietnam to be co-manned," he remarked, "and I think it's the best."

As the only Vietnamese Navy medical officer in the DaNang area at present, Dr. Dieu must devote some of his time to the First Coastal Zone Dispensary, a short distance from NSF's Camp Tien Sha. "I start work at 7:30 every morning at First Coastal Zone Dispensary, remaining there until 10 o'clock," he said; "then I come to NSF Dispensary and work until 5 o'clock in the afternoon, except for lunch."

"On Sunday mornings I visit both dispensaries between 8 and 10 to check on the care of patients," Dr. Dieu reported. "I spend my free time with my new American friends here, and with my relatives in

Vietnamese Navy Doctor Nguyen Dieu consults with patient at DaNang Dispensary.

Vietnamese Civil Service nurse bandages lacerated finger of patient.



Vietnamese Navy Doctor Nguyen Dieu at work.

DaNang." He is on call at any time for emergencies, of course.

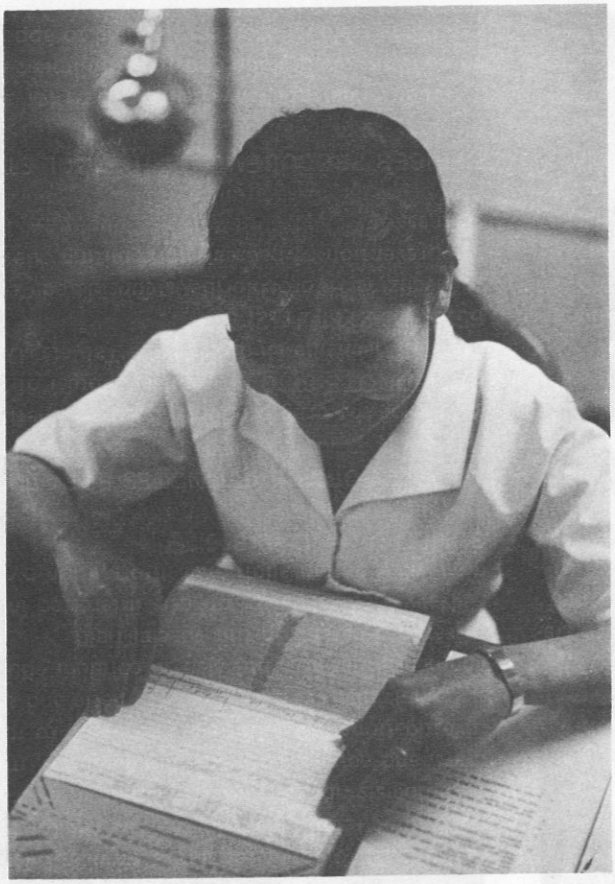
When he becomes more settled, LT Dieu plans to spend Sunday afternoons visiting the Sacred Heart Catholic Orphanage near China Beach, to render medical care for more than 300 orphans there who may need it. "As a bachelor and as a Vietnamese, I feel it is more my duty than any other doctor's to look after the orphans," Dr. Dieu commented, "and I enjoy it."

DISPENSARY, U.S. NAVAL FACILITY DANANG

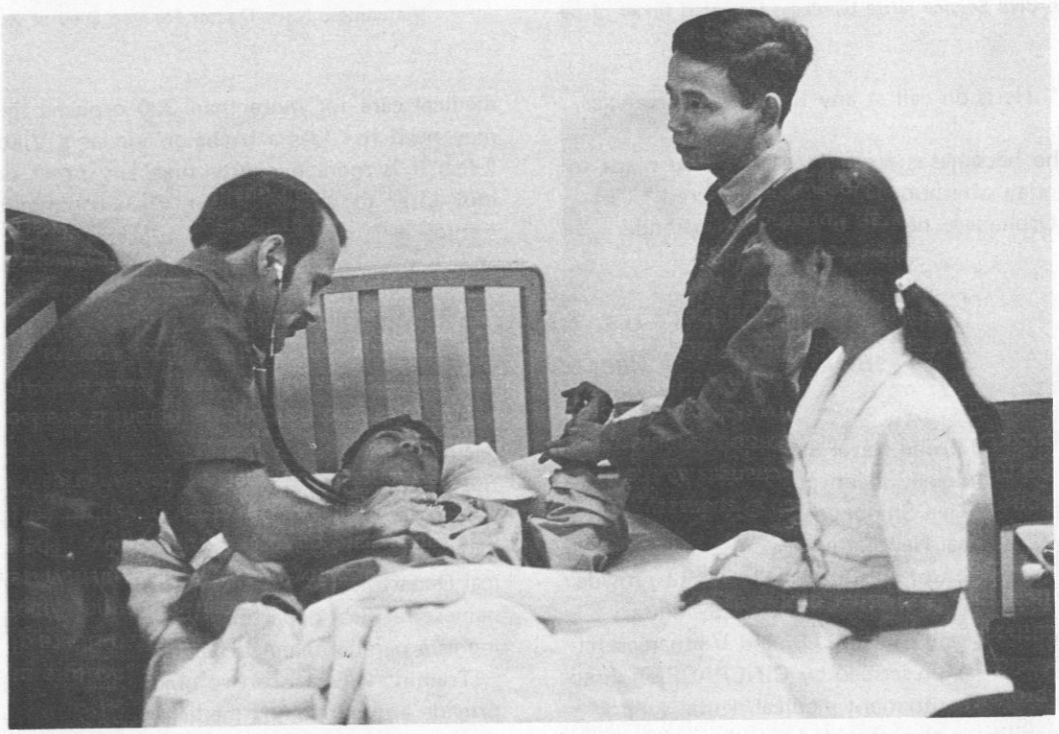
By LT F.F. Briand, MSC, USN, Administrative Officer, Medical Department, NSF DaNang, RVN, April 2, 1971.

On 14 May 1970 the Naval Support Activity Hospital was ceremoniously inactivated. The Dispensary located at Camp Tien Sha opened its doors the next day. (Navy Medical Newsletter 56(2):28-31, Aug 1970.) The mission of this new facility is to provide outpatient medical/dental support to U.S. Military, Vietnamese Navy and certain U.S. and Vietnamese civilian personnel, as prescribed by CINCPACFLT directives. Emergency outpatient medical/dental support within capability is also provided to other military and civilian personnel requiring assistance, as authorized by current MACV and other pertinent directives. With the assignment of a Vietnamese Medical Officer in November of 1970 and gradual acquisition of Vietnamese (VN) hospital corpsmen, the scope of the Medical Department expanded to include training Vietnamese medical department personnel while functioning as a parallel manned facility.

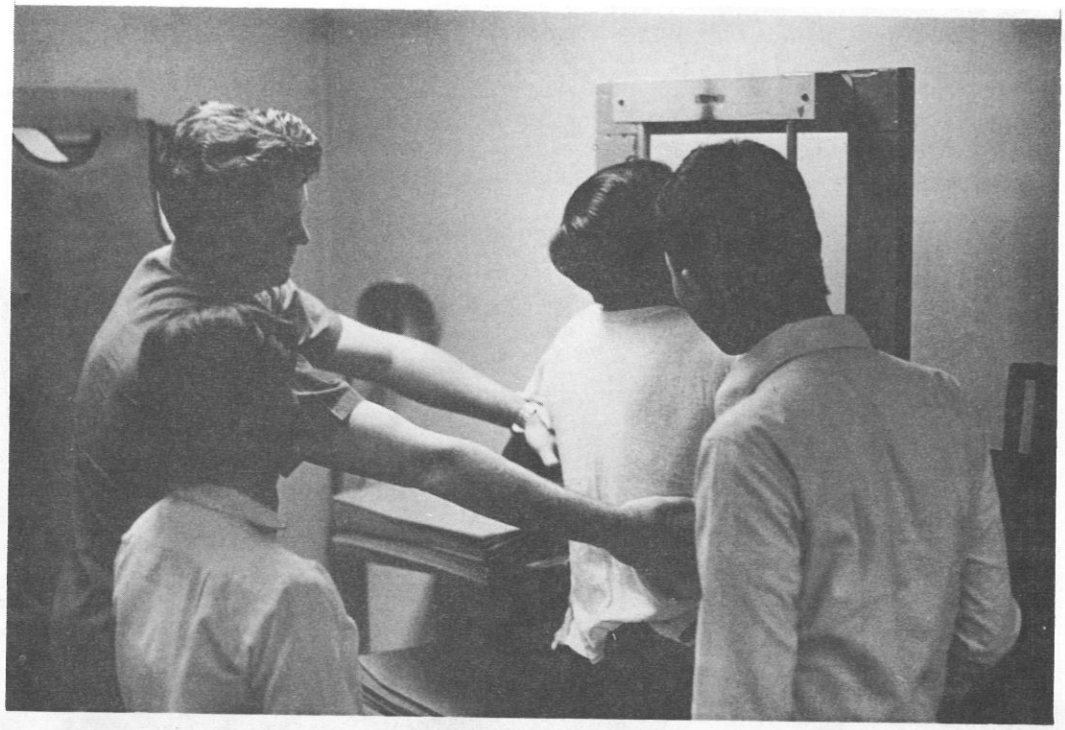
Training will satisfy two objectives. The first is to provide a qualified VN medical staff which will function as a core of experienced and qualified personnel. The second goal is to utilize U.S. medical department



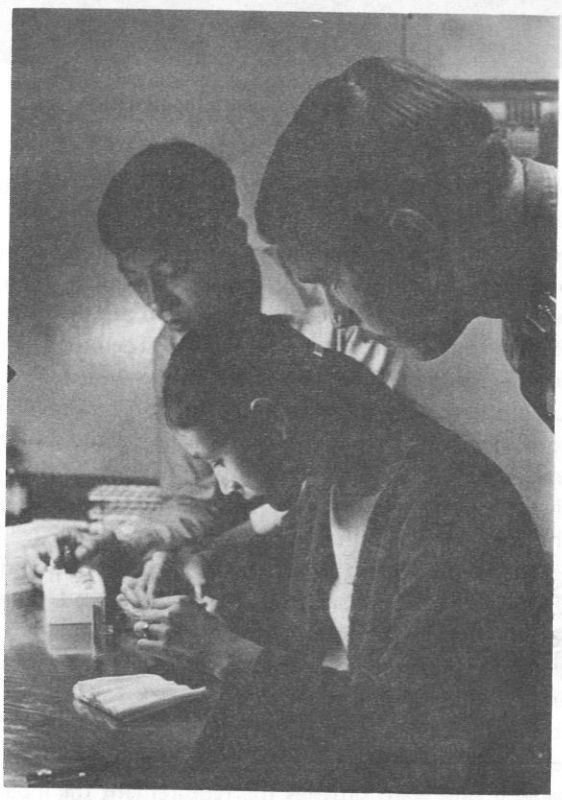
Vietnamese civilian nursing assistant.



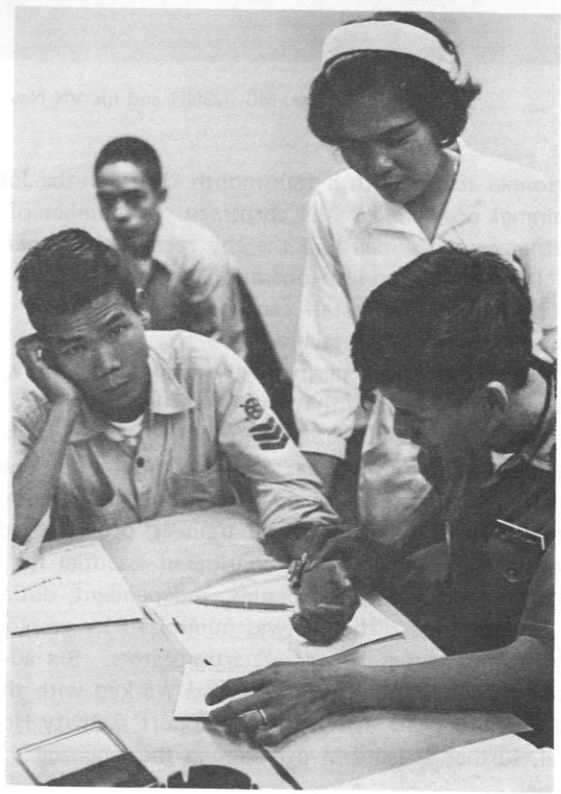
LT James Levernier, MC, USNR, (left), examines a sailor with LTJG Nguyen Dieu, his counterpart physician.



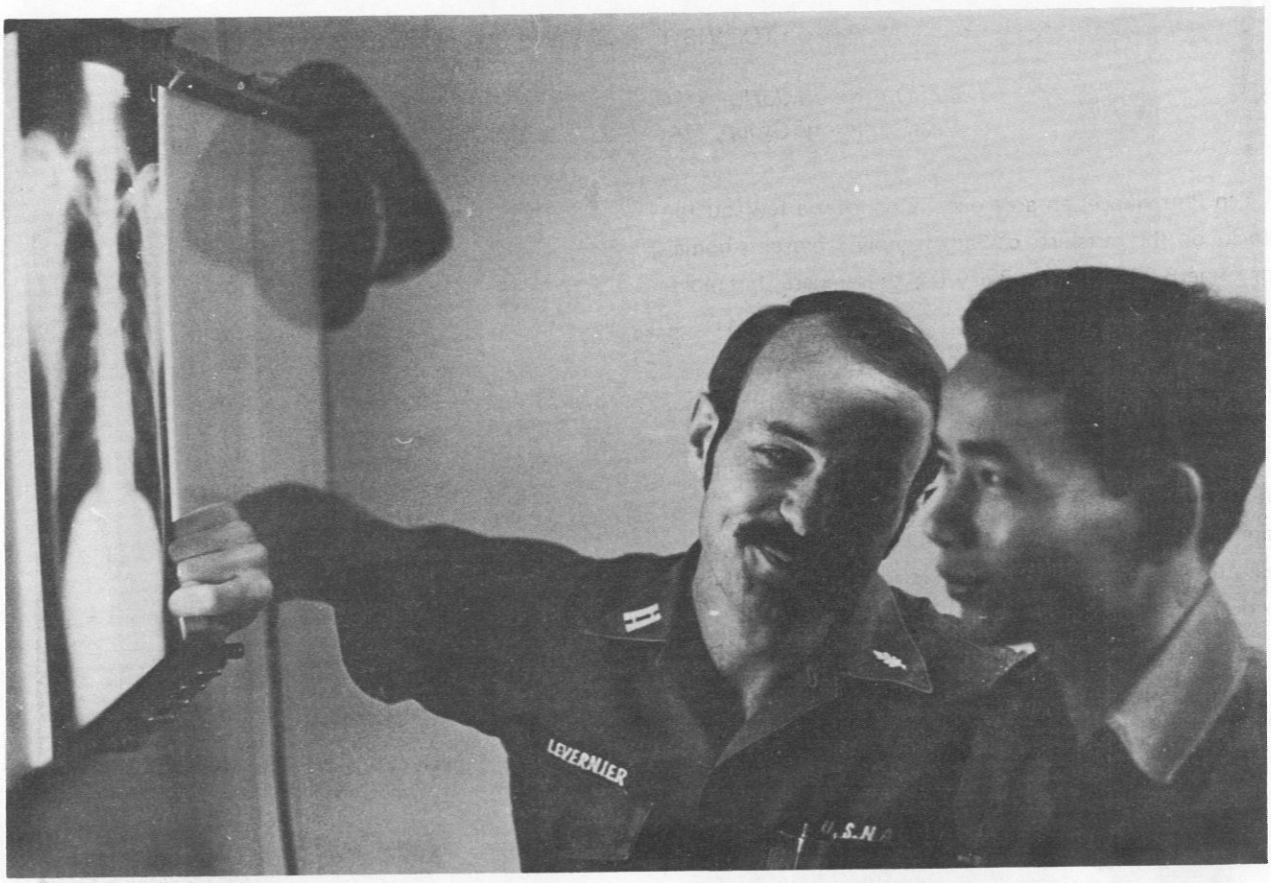
HM1 W.E. Lanigan, USN, (left), instructs his counterpart hospital corpsman and civilian X-ray assistant in the proper techniques for exposing chest X-rays.



HM2 J.R. Sheffield, (right), advises his counterpart VN hospital corpsman and civilian laboratory assistant, in lab procedures.



Vietnamese hospital corpsman Duoing Qang Tro, (right), and OJT Program corpsman assigned to Vietnamese sick call, is screening a VN Petty Officer under the guidance of a civilian nursing assistant.



LT James Levernier, MC, USNR and his VN Navy counterpart, LTJG Nguyen Dieu, are seen in consultation.

personnel to establish a four-month OJT (On-the-Job Training) program for VN corpsmen. A number of Vietnamese corpsmen will thereby receive the benefit of U.S. training, and an operational system will develop which the VN staff can continue after complete turnover of the facility.

VN corpsmen are permanently assigned to the various specialty areas within the Medical Department for thorough indoctrination. Each VN corpsman in these specialty sections has a U.S. counterpart. The OJT program was set up on a rotational basis to insure maximum exposure of all trainees, providing adequate background and skill considered essential for performing general, and possibly, independent, duties.

The language difficulty was minimized by employing two Vietnamese interpreters/translators. Six additional civilian employees who had worked with the U.S. medical staff at the Naval Support Activity Hospital, further assisted in overcoming the language barrier.

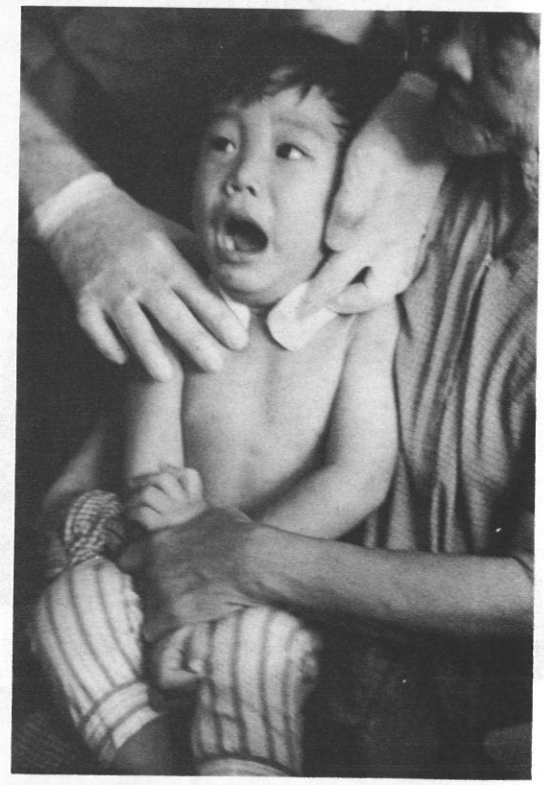
The parallel Medical Department staffs consist of one VN Medical Officer, eight permanent VN hospital corpsmen and four OJT trainees, while in the U. S. contingent are two medical officers, one dental officer, one MSC officer, 12 hospital corpsmen and two dental technicians. The 12 hospital corpsmen are of different NEC's: one Pharmacy Tech, one OR Tech, one Preventive Medicine Tech, one Laboratory Assistant, one Laboratory Tech and one X-ray Tech. The remaining corpsmen perform supply, sick call, ward and administrative duties. This structured organization of qualified personnel is considered suitable for accomplishing the goals of the training program.

The medical plant in which these health care and training services are situated is a modern two-building facility that is roomy, bright and air-conditioned. Two generators provide complete power in the event of an emergency. Complete facilities for sick call, laboratory tests, minor local surgery, pharmacy, X-ray studies, triage and dental services are available. A 28-bed general care ward satisfies the requirement for inpatient treatment capability.

TO VISIT TAN PHU

By JO3 Robert Joffee, USN, U.S. Naval Forces, Vietnam, Naval Advisory Group, MACV. Saigon, RVN, May 1971.

Tan Phu village, an area occupying only a few square blocks on the outskirts of Saigon, now represents home for some 6,000 people. They are Vietnamese, but most have not yet completed their first year "in-country." They had been settled in Cambodia until last July, when political turbulence and war forced them to return to their homeland.

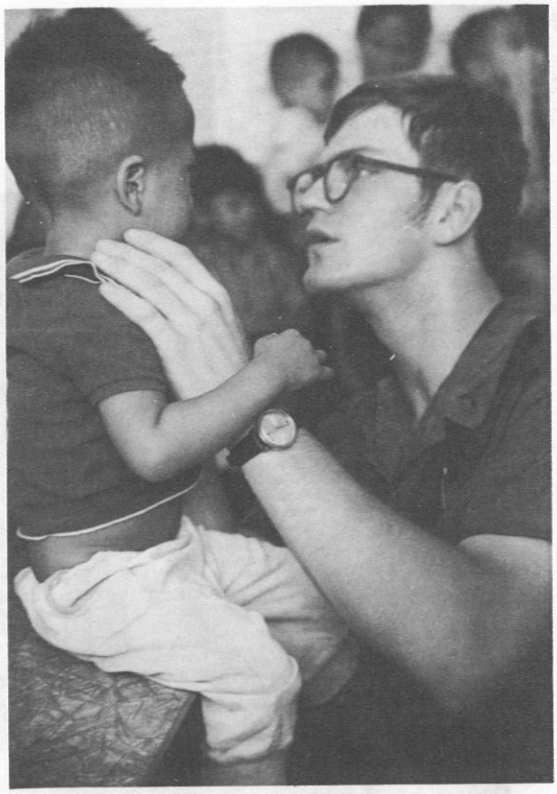


Like refugees anywhere, the residents of Tan Phu present medical problems and there are few trained hands to treat them. Every Wednesday morning, a team of American and Vietnamese Navymen attempts to do something about those problems.

The team, headed by CAPT William T. Lineberry Jr., MC, USN, the Senior Medical Officer on the staff of the Commander, U.S. Naval Forces, in Vietnam, sets up an infirmary in a two-room building at the center of the village. Within minutes of the team's arrival, as many as 200 villagers assemble at the entrance to the building.

In the entry room HM2 Daniel Crane, a hospital corpsman assigned to CAPT Lineberry's office, and two

Curious patients and friends peer into the medical office.



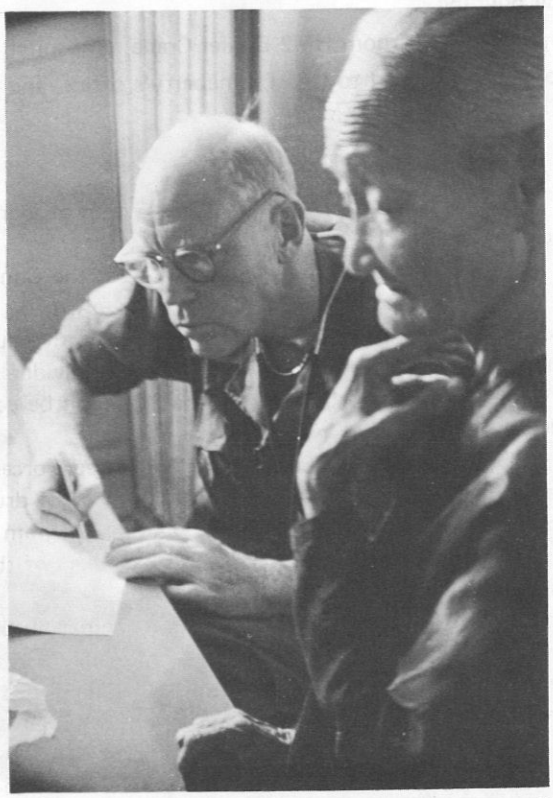
HM2 Crane carefully checks over a young refugee from Cambodia.

corpsmen from the Vietnamese Navy Hospital in Saigon, improvise a combination reception room and pharmacy. One of the Vietnamese corpsmen then joins CAPT Lineberry, serving as an interpreter in the room used for examination and treatment. On a typical morning, the doctor and his men treat a variety of ailments. They often diagnose and refer more serious cases which cannot be treated locally, to hospitals in Saigon.

Sickness and pain are rarely relieved on the spot, and by the time cures are effected, the medical team is usually not around to observe the relief and gratitude reflected in the faces of Tan Phu patients. A three-year-old child does not understand why disinfectant must be painfully applied to his sores, nor does his 72-year-old great-grandmother always comprehend the necessity for an injection.

Despite the frustrations and qualified satisfaction, however, the medical team continues to visit Tan Phu. The opportunity to help a people who need all the help they can get, is irresistible. Would that such a philosophy might motivate all medical organizations on a universal level – to visit "Tan Phu's," everywhere.

CAPT Lineberry and HM2 Crane check the portable pharmacy.



CAPT Lineberry writes a prescription for an elderly lady.

DRUG ADDICTION IN THE MILITARY

What new program has been set up to identify and treat members of the Armed Forces who are addicted to drugs?

1. *Policy:* On June 17, 1971, President Richard Nixon labeled drug abuse "America's public enemy number one" and directed that a four-point program be started immediately by the Secretary of Defense to combat drug addiction in the military. The program will consist of:

o-identification of drug-addicted servicemen in Vietnam,

o-institution of a detoxification program for servicemen before they return to the United States,

o-expansion of treatment programs in the U.S., and

o-development of a worldwide program of identification/treatment.

In addition, the President requested that the Congress pass legislation which will permit the Armed Forces to keep drug dependent persons on active duty for a limited period for treatment if such individuals are due to be discharged before treatment can be completed.

2. *Procedure:* All members of the Armed Forces departing Vietnam will be tested for evidence of drug addiction, and the identification/treatment program will be expanded into all areas where members of the military are stationed.

Trained technicians and diagnostic machinery were airlifted to Vietnam in the early part of June 1971 and centers set up at departure points. Individuals with *negative results* will be returned to the U.S. under normal rotation.

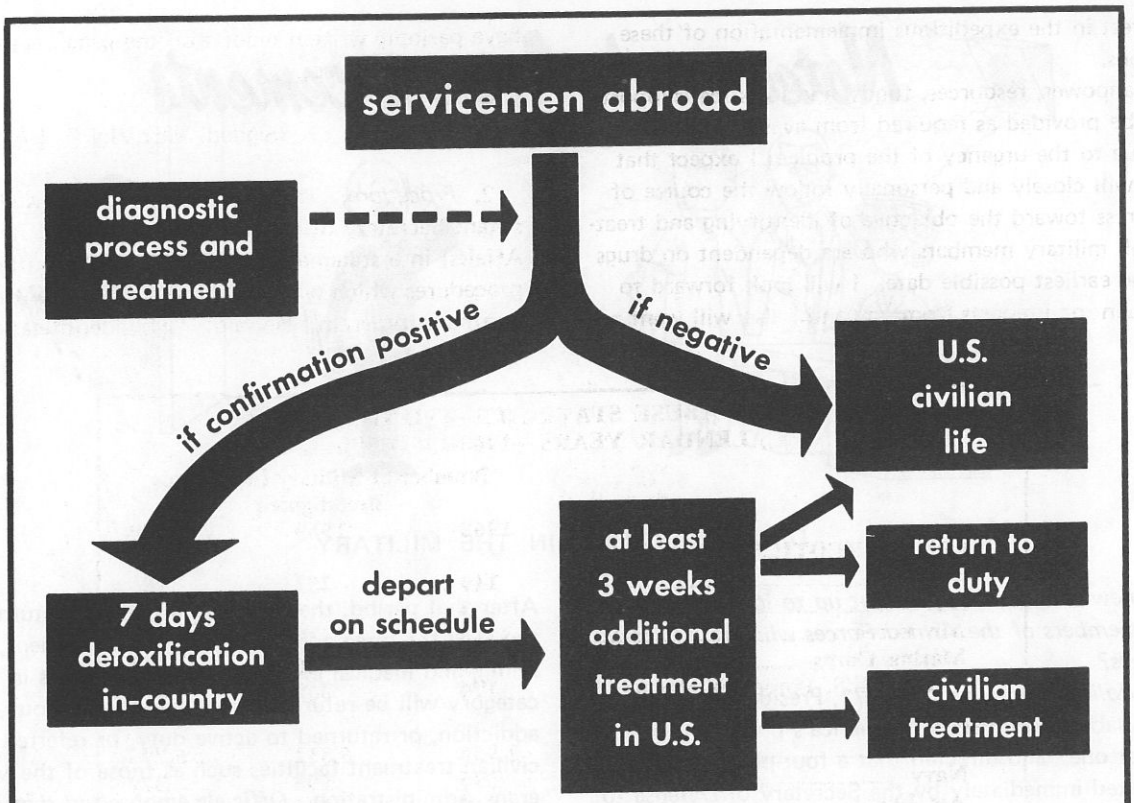
Individuals with *positive results* will be sent to secure, drug-free areas for one week of detoxification. After that period, these individuals will be returned to the U.S. for three additional weeks of treatment, counseling, and medical examinations. Individuals in this category will be returned to civilian life without drug addiction, or returned to active duty, or referred to civilian treatment facilities such as those of the Veterans Administration. *Officials emphasized that confirmation of drug addiction in itself will not result in a punitive discharge.* Specific details will be indicated in a soon-to-be-released DoD Directive.

How will the new identification/treatment program for drug abusers in the Armed Forces work?

1. *Policy:* Reference DoD Information Guidance Series Fact Sheet No. 8B-2, June 1971. The details of the recently announced program for the identification, treatment, and rehabilitation of members of the Armed Forces discovered to be drug abusers were outlined in a Memorandum sent to the Secretaries of the Military Departments and the Chairman, Joint Chiefs of Staff by the Secretary of Defense on June 17, 1971. The Memorandum, directive in nature, reads:

"The President has directed that the critical national problem of drug abuse in the country and in the armed forces be given urgent and immediate attention. I am fully aware of the programs in the services related to drug abuse, but more needs to be done as a matter of urgent priority. As part of the national program addressing this matter the Secretaries of the Military Departments will immediately put into operation plans designed to meet the problem of heroin use among members of the armed forces in Vietnam. Such plans will insure that:

–Within seven days identification is commenced of those service members departing Vietnam who are



Drug Treatment Underway

WASHINGTON (AFPS) — All members of the U.S. Armed Forces departing Vietnam are now being tested for heroin addiction according to a Department of Defense announcement.

This new DoD program of identification and treatment will soon be expanded to all overseas areas where members of the military are stationed.

Servicemen with negative results will be returned to the U.S. under normal rotation.

Individuals with positive results will be sent to medical facilities in Vietnam for up to seven days of detoxification and then returned to the States for further treatment or referral to civilian treatment programs.

Individuals due for separation from the Service before treatment is completed may voluntarily stay on active duty for up to 60 days in order to complete the treatment.

The Services' goal is to return these individuals to civilian life drug free or with a firm referral for further treatment in Veterans Administration or civilian treatment centers.

Servicemen with time remaining to serve will be returned to active duty after successful rehabilitation.

The DoD announcement of the new program emphasized that confirmation of drug addiction in itself in the test will not result in punitive discharge.

using or are dependent on narcotics.

–Service members so identified shall undergo a five to seven day detoxification treatment prior to their return to the United States.

–Service members whose terms of service are expiring who need and desire treatment will be provided the opportunity for a minimum of 30 days of treatment in military facilities in the United States when Veterans Administration or civilian programs are not available.

On the basis of information obtained in the identification and treatment of members departing Vietnam, you will develop and implement at the earliest possible date plans to identify and treat all members in Southeast Asia at least sixty days before the date of their return from overseas.

You will expand on such plans to include at the earliest possible date all service members in Southeast Asia and later worldwide who are dependent on drugs. Studies will also be undertaken to obtain realistic estimates of the extent of drug use in the armed forces.

The President has expressed his keen personal

interest in the expeditious implementation of these actions.

Manpower, resources, funds, and logistical support will be provided as required from available sources.

Due to the urgency of the problem I expect that you will closely and personally follow the course of progress toward the objective of identifying and treating all military members who are dependent on drugs at the earliest possible date. I will look forward to frequent oral reports from you and I also will want to have periodic written reports on the progress made by each of the Services.

(Signed) MELVIN R. LAIRD"

2. *Procedure:* The Honorable Roger T. Kelley, Assistant Secretary of Defense (Manpower and Reserve Affairs) in a statement on June 22, 1971, outlined the procedures which will be followed in the identification/treatment program. He said: "The identification will

DRUG ABUSE STATISTICS—(VIETNAM)
CALENDAR YEARS—1968-1969-1970

	Number of Military Individuals Investigated		
	1968	1969	1970
HARD NARCOTICS			
Army	119	257	726
Navy	3	3	24
Air Force	6	9	50
Marine Corps	46	40	54
Total U.S. Forces (Vietnam)	174	309	854
MARIJUANA			
Army	2,956	5,351	6,790
Navy	336	295	329
Air Force	168	263	254
Marine Corps	728	1,828	1,039
Total U.S. Forces (Vietnam)	4,188	7,737	8,412
DANGEROUS DRUGS			
Army	37	604	1,066
Navy	5	14	57
Air Force	6	15	32
Marine Corps	61	259	394
Total U.S. Forces (Vietnam)	109	892	1,549
	Rate Per 1,000 Investigated		
HARD NARCOTICS			
Army	.36	.74	2.51
Navy	.08	.08	1.09
Air Force	.11	.17	1.13
Marine Corps	.58	.60	1.55
Total U.S. Forces (Vietnam)	.33	.59	2.06
MARIJUANA			
Army	8.92	15.63	23.68
Navy	9.65	8.45	16.21
Air Force	3.11	4.90	5.67
Marine Corps	9.06	25.25	29.81
Total U.S. Forces (Vietnam)	7.99	14.77	20.27
DANGEROUS DRUGS			
Army	.11	1.75	3.73
Navy	.03	.42	2.02
Air Force	.11	.28	.71
Marine Corps	.74	3.84	10.49
Total U.S. Forces (Vietnam)	.21	1.68	3.73

(Chart used June 9 by Assistant Secretary of Defense (Manpower and Reserve Affairs) Roger T. Kelley to discuss drug abuse in the U.S. Armed Forces before the Senate Subcommittee on Alcoholism and Narcotics.) –Washington (AFPS).

be made on the basis of positive results of a biochemical test performed upon a urine specimen, which will be confirmed if positive by a second analysis.

"Service members with confirmed positive urine specimens will be retained in Southeast Asia for a maximum of seven days of medical observation and detoxification.

"The urinalyses for all the services will be conducted by the Army in laboratories established at Cam Ranh Bay and Long Binh, Vietnam. These two locations are also the out-processing centers for the Army for their members who are leaving Vietnam.

"Individuals who test negative will continue their out-processing and return to the United States without delay.

"Service members who test and are reconfirmed positive will remain in Vietnam for a maximum of seven days where they will be observed, evaluated and detoxified. The counseling and treatment will be provided by teams of psychiatrists, medical officers, social worker counselors, and paramedical personnel. After detoxification, they will be returned to the United States.

"The other military services will obtain urine specimens at their own out-processing points. In the Air Force, this will include returnees from Thailand as well as Vietnam. The specimens will be airlifted to the Army laboratories at Cam Ranh Bay and Long Binh for analysis, following which the services will be notified by electrical transmission of those with positive identification of heroin use. Within their own facilities, the Navy, Air Force and Marine Corps will then proceed with out-processing or detoxification as appropriate.

"All service members whose terms of service are expiring, who need and desire treatment because they are dependent upon drugs, will be provided the opportunity for a minimum of thirty days of treatment in military facilities in the United States unless Veterans Administration or civilian treatment programs are available. If such programs are available, military members about to be separated will be referred to them for treatment.

"Service members with time remaining in service will be treated insofar as possible in military programs in the United States and afforded the opportunity for rehabilitation. If extensive treatment is indicated, they will be phased into Veterans Administration programs as such become available.

"It is the policy of the Department of Defense to provide help in the form of needed treatment to military members who need and want such help. Those members who either decline needed treatment or who do not respond sufficiently to treatment given will be separated from their Service and referred to the Veterans Administration or other civilian treatment programs."

Reference: Memo from SecDef to Secretaries of MilDepts, Chairman JCS, dated June 17, 1971; statement by ASD (M&RA) Roger T. Kelley, June 22, 1971, before Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare.—Office of Information for the Armed Forces, DoD, No. 8B-2 and 3.

NAVAL REGIONAL MEDICAL CENTER PORTSMOUTH, VIRGINIA

On 1 July, 1971, the Naval Regional Medical Center, Portsmouth, Va., was established. The center is a shore (field) activity in an operating status under a Director/Commanding Officer, and under the command and support of BUMED. The center is under the immediate area coordination of the Commandant, Fifth Naval District.

The Command consists of the former Naval Dispensary, Norfolk and the medical facilities located at the following naval activities: Naval Amphibious Base, Little Creek; Naval Air Station, Norfolk; Naval Air Station, Oceana; Fleet Anti-Air Warfare Training Center, Dam Neck; Naval Supply Center, Norfolk; Naval Weapons Station, Yorktown; Armed Forces Staff College Administrative Command, Norfolk; Norfolk Naval Shipyard, Portsmouth; and Naval Communications Station, Norfolk. The majority of the Center administrative departments are located aboard the Naval Hospital compound. The Naval Hospital, Portsmouth, remains a separate command, but functions as an integral element of the Tidewater Navy Health Care System, as does the Center. The Naval Regional Medical Center (NRMC) and the Naval Hospital are under the command of RADM Joseph L. Yon, MC, USN. Deputy Director of the NRMC is CAPT Willard P. Arentzen, MC, USN (Rear Admiral Selectee).

For the first time in Navy history, the majority of fixed ashore Navy medical facilities in a geographic area will be under the command of a single Regional Medical Director/Commanding Officer. This new concept will allow for increased and improved health care services for all authorized beneficiaries, improved patient/staff/command satisfaction, and more efficient and effective use of Navy health care resources in the Tidewater area. Among the innovations planned are: (1) a realignment of patient care responsibilities, (2) extended hours of operation at selected facilities,

(3) expanded medical specialty services at selected sites, (4) standardized availability of drugs and medications, and (5) improved medical records management. The Regional Medical Director provides a single, local responsible authority for immediately resolving complaints, deficiencies, and other problems relating to medical care, resources and facilities.

Renovation of the NRMC Branch Dispensary, NAS, Norfolk, and minor physical plant changes at the NRMC Branch Dispensary, Naval Station, should be completed in August 1971. Military sick call and other active duty medical care will then be moved to the NRMC Branch Dispensary, NAS; the NRMC Branch Dispensary, Naval Station, Norfolk, will then become the outpatient treatment center for the Sewell's Point area dependents and retired personnel. Specialty clinics from the Naval Hospital, Portsmouth, are to be phased in during August. Upon completion of the new dispensary, a similar plan will be placed into operation at Little Creek.

ENTER DR. WILBUR AS DR. ROUSSELOT RESIGNS

Dr. Richard S. Wilbur, Deputy Executive Vice President of the American Medical Association in Chicago, has been named to succeed Dr. Louis M. Rousselot as Assistant Secretary of Defense (Health and Environment).

Dr. Rousselot resigned from the position June 17, citing "personal reasons" in a letter to Secretary of Defense Melvin R. Laird. He had served three and a half years with the Defense Department.

In a letter to Dr. Rousselot accepting his resignation, Secretary Laird wrote: "Your work to strengthen the Defense Health Program and establish the Defense Environmental Quality Program has provided the Department with a firm foundation from which to administer these activities. We appreciate your efforts and recognize the significance of your contributions."

Dr. Rousselot will remain in office until the Senate confirms Dr. Wilbur's appointment, officials noted.

Dr. Wilbur, who served as a U. S. Navy physician from 1947 to 1949, graduated from Stanford University in 1943 and received his doctorate from the same institution's medical school in 1946. A specialist in internal medicine, he practiced medicine at the Palo Alto Medical Clinic, Palo Alto, Calif., from 1952 until 1969, when he moved to Chicago to take up his duties with the AMA.—Washington (AFPS).

RESIDENCY TRAINING IN FORENSIC PATHOLOGY

Since 1962, the Armed Forces Institute of Pathology has been approved by the American Board of Pathology and the Council on Medical Education, American Medical Association for one year of residency training in the special field of forensic pathology. The program is listed in the current Directory of Approved Internships and Residencies published by the American Medical Association.

This advanced residency program is available to military pathologists of the Army, Navy and Air Force who meet the prerequisites. The program is approved for four residents each year.

The Armed Forces Institute of Pathology is the only medical facility of the military services approved for advanced training in this special field. The program is conducted by a well qualified staff of Army, Navy and Air Force forensic pathologists.

Forensic pathology is closely related to the interests of military medicine, and in the future it is hoped that a sufficient number of pathologists, certified in the fields of anatomic, clinical, and forensic pathology, will be available not only to serve on the staffs of each military teaching hospital, but also to serve as regional consultants for their respective services. There is a continuing requirement in the services for forensic pathologists not only to participate in aircraft, landcraft, and aquatic accident investigations, medicolegal investigations, consultations pertaining to forensic medicine, and the evaluation of traumatic and toxic environmental hazards, but also to conduct educational and research programs in this special field.

Navy Medical Corps officers interested in this program may obtain additional information by writing to BUMED (Attn. Code 316).

FORMULARY NOTES ERRATUM

One of the drug products listed as "ineffective" in BUMEDNOTE 6710 (Formulary Notes) of 26 February 1971 is Meclizine Hydrochloride Tablets, USP (FSN's 6505-926-2111/2112).

Meclizine Hydrochloride is considered "effective" for the prevention of nausea and vomiting due to motion sickness.

OFFICER PROCUREMENT PHYSICAL STANDARDS

Traditionally the physical standards for appointment to commissioned grade and for enrollment in officer candidate training programs leading to appointment

have been different than those for enlistment or induction. The Navy and Marine Corps have always required a higher degree of physical fitness for appointment (Chapter 15, MANMED) than for enlistment or induction (AR 40-501, Chapter 2). The most commonly cited reason for this difference is that an officer's assignment must cover a wider variety of duties in order to develop and broaden his qualifications for promotion. Certain physical defects in officers tend to limit the area of their assignment, interfere with their planned career development, and reduce the overall flexibility in rapidly changing technical and operational situations, particularly in time of war. On the other hand, the enlisted member's career is normally confined to a single occupational specialty. The physical demands that these specialties place upon the enlisted member vary to a sufficient degree to allow for suitable selection of a specialty for enlisted members who have certain physical limitations. The Army, on the other hand, generally applies the same entrance physical standards for enlistment as for appointment to commissioned grade (Chapter 2 of AR 40-501). The Air Force plans to adopt a similar policy for other than flight personnel.

In light of the action being taken by our sister services to adopt a more or less single set of physical standards for entrance into the Army and Air Force for all categories except special duty assignments, the Physical Qualifications and Medical Records Division (PQ & MR Div) of BUMED was requested to review the Navy's current officer and enlisted procurement physical standards to determine if the Navy and Marine Corps could also adopt, in toto, the entrance standards set forth in Chapter 2 of AR 40-501. The services of various specialists of the Navy Medical Department, in the Washington, D.C. area, were utilized in evaluating the various standards and their application to the Navy's operational assignments. Because of the unique operational requirements of the Navy and Marine Corps, it was determined that the standards set forth in Chapter 2 of AR 40-501 could not be adopted in toto. On the other hand, several changes were approved, within the Department of the Navy, for adoption. These changes will be promulgated in a forthcoming change to the Manual of the Medical Department (Articles 15-7 through 15-25A). Although there were many minor changes, the major changes involve the standards for height, visual acuity and hearing.

It is requested that all medical officers who conduct physical examinations on applicants for entrance into our various officer procurement programs familiarize themselves with the new changes when received. Medical officers having questions concerning these changes or other physical standards are invited to call BUMED (Code 3322), Autovon 22-24465 or commercial, Area Code 202, 692-4465.—BUMED, Code 33.

OB/GYN NURSE CLINICIAN PROGRAM

A Nurse Clinician Program is being established to train selected Nurse Corps officers to function in Obstetrics and Gynecology in an Ambulatory Health Care Setting as an associate to, and under the direct supervision of, a physician. Areas of responsibility will include uncomplicated prenatal care, prenatal education, GYN screening and examination, and family planning.

It is anticipated that the program will aid in reducing appointment backlog and patient-waiting time, thus improving patient care and satisfaction. Also it is considered that the program will increase Medical Corps and Nurse Corps officer retention by permitting the nurse to expand her role in the health team, while permitting the obstetrician/gynecologist to effectively treat the more complicated patient.

The program will involve six months on-the-job training at the Naval Hospital, Portsmouth, Va., with classes restricted to six officers. The first six-month course convening in Oct. 1971 will include a significant didactic period, with physician-demonstrated and physician-supervised clinical experience in techniques of history taking, physical examination, diagnostic procedures, and limited treatments. Applicants must have a broad background of OB/GYN experience, be recommended and willing to obligate for an additional year of service. Applications may be submitted to BUMED (Code 324) in accordance with BUMEDINST 1520.14A for full time instruction.

PEDIATRIC NURSE PRACTITIONER

Qualified Navy Nurse Corps officers will soon be selected to participate in recognized outservice programs to train as Pediatric Nurse Practitioners. These Nurse Corps officers will be utilized in their expanded role to help meet the pressing need throughout the Navy to provide optimal health care to children. They will function as an associate to, and under the direct supervision of a physician, in ambulatory patient care settings. Their responsibilities will involve them in diagnostic, preventive and therapeutic branches of Pediatrics.

Applicants must be augmented to regular Navy, willing to obligate for additional service, and be recommended for participation. A minimum of one year of

experience in Pediatrics is required and a B.S. in Nursing is desirable. Interested Nurse Corps officers are advised to submit applications to BUMED (Code 324) in accordance with BUMEDINST 1520.14A for full time duty under instruction. All applicants shall be available for a personal interview prior to selection.

NAVY NURSE CORPS CONTINUING EDUCATION

The Navy Nurse Corps has announced a new series of educational short courses to be held at the Naval Medical School, National Naval Medical Center, Bethesda, Md., for FY 1972. These courses are available to Nurse Corps officers not currently assigned to an overseas billet who have served a minimum of six months' active duty. Applications should be submitted several weeks in advance of the desired conference to BUMED (Code 324) in accordance with BUMEDINST 1520.14A.

The program for FY 1972 is as follows:

Medical Nursing Symposium, 16-20 Aug. 1971;
Coronary Care Course, 8-19 Nov. 1971;
Postgraduate Anesthesia Conference (For Nurse Anesthetists only), 6-10 Dec. 1971;
Surgical Nursing Symposium, 24-28 Jan. 1972;
Rehabilitation Nursing Workshop, 13-17 Mar. 1972;
Inservice Education Workshop (For Educational Coordinators, Instructors, and persons planning inservice programs), 24-28 Apr. 1972;
Improved Patient Care Through Effective Leadership (For senior lieutenants and above), 12-16 June 1972.

MSC INSERVICE PROCUREMENT

The FY 1972 Annual Medical Service Corps Inservice Procurement Program is now complete. Forty-one enlisted members and one officer have been selected and approved for appointment. Before reporting to their next duty station, those selected will attend the indoctrination class at the Naval School of Health Care Administration, NNMC, Bethesda, Md. LTJG Ronald D. Porter will drop a grade in order to enter the allied sciences field. Also included for appointment in the allied sciences field are a machinist's mate and an electrician's mate, both of whom will work in radiation health. Twenty-eight alternates for appointment have been named and will be commissioned in FY 1972 if vacancies occur.

Selected for appointment in *Health Care Administration* were:

HM1 Barber, Norman J.
HMC Crabtree, Roger D.
HM1 Dial, William S.
HM1 Fristad, Arvid C.
HM1 Greenan, John E.
HM1 Hetrick, John R.
HM1 Hickey, Rodney D.
DTG1 Hixson, Steven R.
HMC Holman, Larry D.
HMCS Hughes, Francis J.
HMC Huju, John I.
HM1 Johnson, David E.
HM1 Kane, Robert J.
HM1 Knee, Dale O.
HM1 Kunkel, Clyde E.
HM1 Kurtich, Richard B.
HM1 Lemmerman, Donald J.
DT1 Malinky, Robert L.
HM1 Martin, Donna R.
DTGC Morey, Arlen D.
HMC Mullin, Jimmie J.
HM1 Peters, Anthony J., III
HM1 Peterson, Jack L.
HMC Ruffin, Tommy L.
HM1 Schick, Gary E.
HMC Shannon, Kenneth R.
HMC Sheridan, Peter F.
HM1 Smith, Steven L.
DT1 Thompson, J. Ronald
DT1 Todd, Michael L.
HM1 Tomlinson, Tommy M.
HM1 Waggoner, Lemuel A.
DTG1 Weappa, Larry R.
HMC Williams, Warren Jr.
HM1 Yost, Harry E.

Selectees for appointment in *Allied Sciences and Pharmacy* were:

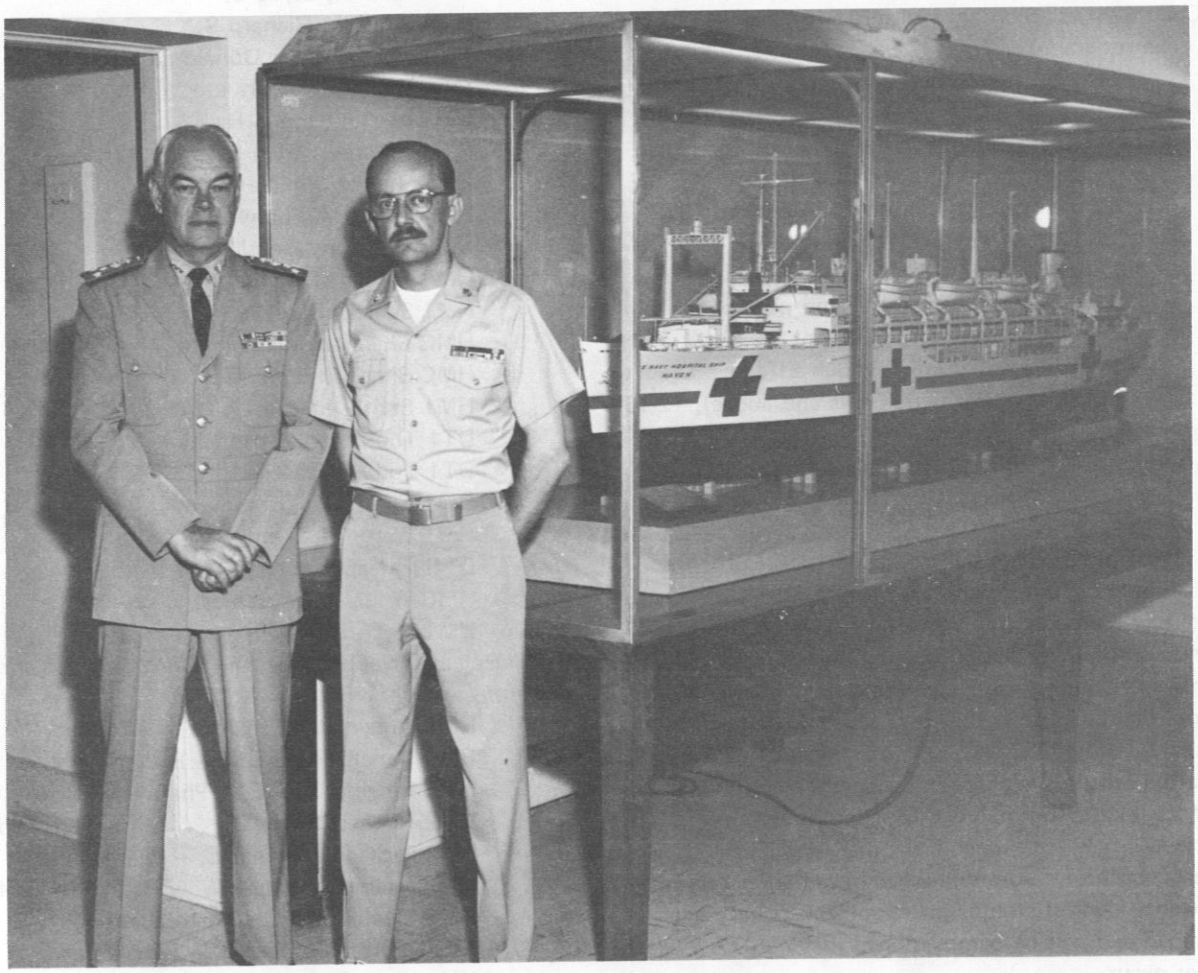
HM3 Anderson, Richard L. – Pharmacy
HM3 Debell, Robert M. – Bacteriology
HM3 Herring, Paul E. – Pharmacy
HM2 Hughes, Roger D. – Medical Technology
HM3 Jackson, Thomas C. – Pharmacy
MM3 Malinoski, James W. – Radiation Health
HM2 Mueller, Eric J., II – Bacteriology
LTJG Porter, Ronald D. – Biochemistry
HM3 Wolf, Richard – Environmental Health.

OLD PHOTOGRAPHS FOR OLD SALTS

Nostalgic sailors and others interested in obtaining photographs of Navy ships may do so from the National Archives and the Naval Photographic Center.

Ship photographs taken before 1958 may be ordered from the National Archives and Records Service, Attention: Cashier, Room 408, 8th and Penn. Ave., N.W., Washington, D.C. 20408. A check for $2 payable to the General Services Administration must accompany the request.

Photographs of ships from 1958 may be obtained by writing the Commanding Officer, Naval Photographic Center, Naval Station, Washington, D.C. 20309. The cost is 90 cents for an 8 x 10 black and white glossy photo. Additional prints from the same negative are priced at 40 cents. Checks should be made payable to the Naval Photographic Center, Naval Station, Washington, D.C. 20309.—Washington (AFPS).



VADM G.M. Davis, (left) is pictured with HMC R.M. Johnsen, USN, (right), BUMED Code 49, who was instrumental in procuring a scale model of the USS Haven (AH-12) for display at the main entrance to BUMED Building 1. On loan from the Naval Ship Systems Command, the technical ship model was recently overhauled and refurbished. Previously loaned to Naval Hospital St. Albans, New York, the model was also exhibited at the last New York World's Fair. During the Korean conflict, VADM George M. Davis, MC, USN, Surgeon General, served as Chief of Medicine on the staff of the Naval Hospital in USS Haven from November 1952 to May 1954.

United States Navy Medicine

CORRESPONDENCE AND CONTRIBUTIONS from the field are welcomed and will be published as space permits, subject to editing and possible abridgment. All material should be submitted to the Editor, U.S. Navy Medicine, Code 18, Bureau of Medicine and Surgery, Washington, D.C. 20390

NOTICES should be received not later than the third day of the month preceding the month of publication.

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SUGGESTIONS are invited concerning U.S. Navy Medicine, its content and form.

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